SCHOOL DISTRICT OF HENDRY COUNTY

Section IX

Proposal Forms for Fully Insured Group Medical Insurance

SECTION IX

THE SCHOOL DISTRICT OF HENDRY COUNTY

FULLY INSURED GROUP MEDICAL INSURANCE

PROPOSAL FORMS

A. PROPOSER'S IDENTIFICATION

Name of Insurer: ____________________

FEIN/SS#: ____________________

Address: ____________________

____

____

Insurer Proposal Contact: ____________________

Telephone Numbers Daytime/After Hours: ____________________

E-mail: ____________________

B. IF APPLICABLE – INSURANCE AGENCY(IES)/AGENT(S)

NOTE: If one or more agencies/agents are acceptable to the proposing insurer, please list those firms and representatives which you approve, if the School District should decide on a proposal other than directly through the proposing insurer's employee agent:

	Agency	Agent
1.	____________________	____________________
2.	____________________	____________________
3.	____________________	____________________

NOTE: If an agent(s) is/are listed, the Agents proposal forms at the end of this document, Section XII - Agent/Broker Services must be completed by each of such agent(s).

FULLY INSURED MEDICAL INSURANCE COST INFORMATION

Please complete the charts below for the requested plans including all three (3) Aetna plans. Please propose your benefit plans as described below and shown in **Exhibit 3 (a,b,c) Benefits Match-up.**

All deviations from the requested plan design(s) must be listed on a separate page.

PPO Medical Plan – PLAN 1
Rates/Annualized Premium

Same as or reasonably similar to current Aetna MC Plan 1 - No changes

PPO – MEDICAL AND RX BENEFITS Unlimited Lifetime Maximum Your Plan Name, Number, Type ________________________							
For 1/1/2023 ($220,000 pooling):	#	X	$Rate	X	12	=	Annual Premium
Employees/Retirees/COBRA Only	767	X	$	X	12	=	$
Employee/Retiree/COBRA + Spouse	20	X	$	X	12	=	$
Employee/Retiree/COBRA + Child(ren)	19	X	$	X	12	=	$
Employee/Retiree/COBRA + Family	17	X	$	X	12	=	$
Total Plan 1 Premium							$

PPO Medical Plan – PLAN 2
Rates/Annualized Premium

Same as or reasonably similar to current Aetna Plan MC 2 – No changes

PPO – MEDICAL AND RX BENEFITS Unlimited Lifetime Maximum Your Plan Name and Number ________________________							
For 1/1/2023 ($220,000 pooling):	#	X	$Rate	X	12	=	Annual Premium
Employees/Retirees/COBRA Only	19	X	$	X	12	=	$
Employee/Retiree/COBRA + Spouse	18	X	$	X	12	=	$
Employee/Retiree/COBRA + Child(ren)	60	X	$	X	12	=	$
Employee/Retiree/COBRA + Family	12	X	$	X	12	=	$
Total Plan 2 Premium							$

High Deductible/HSA Medical Plan – PLAN 3

Rates/Annualized Premium

Same as or reasonably similar to current Aetna Plan 3 – HRA/HSA – no changes

HDHP/HRA (single) HSA (family) – MEDICAL AND RX BENEFITS Unlimited Lifetime Maximum Your Plan Name and Number ________________________________							
For 1/1/2023 ($220,000 pooling):	#	X	$Rate	X	12	=	Annual Premium
Employees/Retirees/COBRA Only	24	X	$	X	12	=	$
Employee/Retiree/COBRA + Spouse	4	X	$	X	12	=	$
Employee/Retiree/COBRA + Child(ren)	18	X	$	X	12	=	$
Employee/Retiree/COBRA + Family	4	X	$	X	12	=	$
Total Plan 3 Premium							$

Total Annual Premium for all three (3) plans	**$**

For Medical & Rx Services:

1. Is agent/broker remuneration included in your fees or rates?
   Yes ____ No ____

2. Please indicate the manner in which remuneration is calculated:
   Percentage of premiums: Indicate percentage _______%
   Other amount: Indicate annual amount $________

3. Regardless of the remuneration method utilized, provide an estimate of the annual remuneration payable. $________________

RETENTION

Three (3) Plan Options. Propose Benefits As-Is.

Retention for all three (3) fully insured plans based on per employee per month cost

Show these monthly rates and annual cost in the table below if the rates are the same for all three (3) plans being offered. However, if the rates are different for two or more of the plans, create an additional table(s) for each plan(s) that are different. Make sure that if you add one or more tables to account for different rates that the total of all tables equals total annual cost for all plans.

	RETENTION COST FOR 1/1/2023-12/31/2023	**#**	**X**	**$Rate**	**X**	**12**	**=**	**Annual Cost**
1.	Claims service cost	982	X	$	X	12	=	$
2.	Network access fees, if any	982	X	$	X	12	=	$
3.	Wellness Program (attach explanation)	982	X	$	X	12	=	$
4.	COBRA administration cost *	982	X	$	X	12	=	$
5.	HIPAA administration cost	982	X	$	X	12	=	$
6.	PPACA Insurer Fee	982	X	$	X	12	=	$
7.	PCOR Fee	982	X	$	X	12	=	$
8.	Transitional Reinsurance Fee	982	X	$	X	12	=	$
9.	Additional PPACA items (please list and explain)	982	X	$	X	12	=	$
10.	Premium taxes	982	X	$	X	12	=	$
11.	Commissions, finders fees or other remuneration to insurance agent **	982	X	$	X	12	=	$
12.	Enrollment meetings and materials	982	X	$	X	12	=	$
13.	Printing of booklets, plan documents	982	X	$	X	12	=	$
14.	Other charges (explain)	982	X	$	X	12	=	$
15.	Profit	982	X	$	X	12	=	$
	TOTAL RETENTION COST							**$**

* Proposers should clearly state if COBRA services are to be provided by an outside firm, charging extra.

** Proposers offering proposals through insurance agencies should propose net of any remuneration, which should be left up to the proposing agencies/agents to separately indicate later herein. If such a proposal is accepted, such remuneration will be added to the rates proposed to determine total rates to be charged.

1. Are these costs flat charges, minimum or maximum charges or variable based on claims?

2. Are any of your administration fees not guaranteed and/or subject to final retroactive accounting at the end of each plan year?

3. List any assumptions, limitations, or exclusions that are conditions of the retention costs your company is proposing. Indicate any impact to your proposed premiums/fees if any of these conditions are not met.

4. Confirm that your cost includes payment of run-out claims and extension of benefits claims of disabled persons (the School District is obligated to pay claims as required by Florida Statute 627.667(3)(a) for up to 12 months after plan termination). If your cost is not included, provide the additional cost for such coverage.

CLAIMS PROJECTIONS

PPO PLAN 1________________(state plan name/#) CLAIMS PROJECTIONS	**Next 12 Months**
Estimate of 01/01/2023 – 12/31/2023 paid claims	$
Estimate of 01/01/2023 – 12/31/2023 incurred claims	$
Medical claims trend factor	1.

PPO PLAN 2________________(state plan name/#) CLAIMS PROJECTIONS	**Next 12 Months**
Estimate of 01/01/2023 – 12/31/2023 paid claims	$
Estimate of 01/01/2023 – 12/31/2023 incurred claims	$
Medical claims trend factor	1.

HDHP/HSA PLAN 3_____________(state plan name/#) CLAIMS PROJECTIONS	**Next 12 Months**
Estimate of 01/01/2023 – 12/31/2023 paid claims	$
Estimate of 01/01/2023 – 12/31/2023 incurred claims	$
Medical claims trend factor	1.

All 3 Plans CLAIMS PROJECTIONS	**Next 12 Months**
Estimate of 01/01/2023 – 12/31/2023 paid claims	$
Estimate of 01/01/2023 – 12/31/2023 incurred claims	$

Pooling of Claims

POOLING point - State the annual premium for:	**Annual Premium**
Pooling charge for **$250,000** pooling point	$

Medical Cost Sharing/Cost Control, Renewal Caps/Guarantees, etc.

1. What rate/cost guarantees/caps/ceilings are you providing beyond the first 12 months, e.g. renewal retention, renewal trend, profit or other? Provide details and number of years.

2. Are you offering the School District a profit/risk sharing option? Explain, and provide complete details if there are requirements or contingencies involved.

    a. If the program generates a surplus, will dividends or other return moneys be payable? When?

    b. Does your contract provide for a deficit carry-forward? If yes, explain the method of recouping deficits in future years.

    c. If upon termination of the plan excess moneys remain after payment of all claims and expenses, will such excess moneys be refunded to the School District? When?

    d. If upon termination of the plan there is a deficit at the termination date or thereafter, will the deficit be forgiven? If not, explain.

FULLY INSURED MEDICAL INSURANCE COST QUESTIONS

Attach necessary explanations and/or deviations.

1. What is the range of required enrollment for each option offered? State here if there are any required minimums.

2. For what range of employees and retirees are the proposed costs applicable (e.g. within 5%, 10%, etc. of the census)

3. If the number of enrollees is less than the plan members in the census data, but the age and sex mix are not materially different, will you honor your proposal as proposed?

4. Will you agree to negotiate changes in proposed benefits and/or premiums, administration and other costs, if the School District should desire to do so?

5. Are you agreeable to negotiate variations in the rates proposed, if the School District wishes to increase or decrease the rate distribution between employees and dependents, or between plans offered?

6. Are you able to provide a telemedicine benefit with your proposal offering? If the company providing the service is a third party, that is acceptable. Please describe the details of what the offering is, the company who can provide it and any additional costs, if applicable.

7. Is there any additional cost for HIPAA administration? Who is providing HIPAA administration? Explain and provide details.

8. Are there any additional costs for COBRA? Who is providing the COBRA administration? Explain and provide details.

9. For the COBRA administration, the School District would prefer a COBRA administrator that can also administer all COBRA required coverages that are offered by the School District. Are you able to administer coverages other than medical? Explain.

10. To what extent do you coordinate benefits and subrogate with other insurance sources of participants? What savings do you typically generate from each source?

11. Identify approximate medical network provider discounts in the following counties for the plans you are proposing:

Hendry County

	Discount off billed charges	Explanation
PPO Physicians		
HDHP Physicians		
PPO Hospitals		
HDHP Hospitals		

Lee County

	Discount off billed charges	Explanation
PPO Physicians		
HDHP Physicians		
PPO Hospitals		
HDHP Hospitals		

Palm Beach County

	Discount off billed charges	Explanation
PPO Physicians		
HDHP Physicians		
PPO Hospitals		
HDHP Hospitals		

Charlotte County

	Discount off billed charges	Explanation
PPO Physicians		
HDHP Physicians		
PPO Hospitals		
HDHP Hospitals		

Glades County

	Discount off billed charges	Explanation
PPO Physicians		
HDHP Physicians		
PPO Hospitals		
HDHP Hospitals		

Highlands County

	Discount off billed charges	Explanation
PPO Physicians		
HDHP Physicians		
PPO Hospitals		
HDHP Hospitals		

Collier County

	Discount off billed charges	Explanation
PPO Physicians		
HDHP Physicians		
PPO Hospitals		
HDHP Hospitals		

12. Is a specific lab company required to be used by members? Describe your contracted arrangements for laboratory work. Is the lab arrangement capitated? Describe the discounts and terms.

PRESCRIPTION COST QUESTIONS

Attach necessary explanations and/or deviations.

1. For the School District's size and medical and prescription experience, what would you recommend to the School District to control escalating prescription costs?

2. Please describe any generic prescriptions available to members at a reduced or zero cost share. Are you able to match the current "Free Preventative Medications" and "Free Preventative Generic Medications" lists?

3. What additional programs can the School District consider for prescriptions? I.e. 90-day retail option, generic usage program, step therapy, etc. Please note the current programs they are participating in and also describe the options available and if there are any additional costs.

4. Provide your recommendations on how to improve generic utilization. Explain.

5. Is the mail order pharmacy owned by the proposing company or is it outsourced? If outsourced, to which mail order pharmacy company and why? Explain the benefits of this mail order service.

6. What incentives do you recommend to encourage participants to use the mail order service?

7. What controls do you recommend to minimize over-utilization and/or fraud in connection with the mail order service?

8. Is the specialty pharmacy owned by the proposing company or is it outsourced? If outsourced, to which specialty pharmacy company and why? Explain the benefits of this specialty pharmacy.

9. What initiatives do you employ against other types of claims fraud and are there any additional costs for these initiatives?

10. Describe the extent to which you perform any screening to detect possible multiple drug interactions/reactions and your procedure for notifying participants.

EMPLOYEE ASSISTANCE PROGRAM COST QUESTIONS

1. What are the proposed costs for the EAP services and for how many visits?

2. Are there any cost guarantees? For how many months?

3. Are there any additional costs for any of the requested services? Explain and provide details.

MEDICAL AND PRESCRIPTION COVERAGE QUESTIONS

Attach necessary explanations and/or deviations.

1. Have you provided the Benefits Match-up a,b,c (Exhibit 3 in Word format)?

2. Are the plans proposed file and approved with the State of Florida for 1/1/2023? If not, explain.

3. Have you provided descriptive material on all medical benefits provided and all limitations and exclusions?

4. Will you provide ongoing PPACA (Healthcare Reform) guidance, updates and resources? Explain.

5. How will you assist the School District in remaining in compliance with the PPACA, specifically with:
    a. Guaranteed Availability of Coverage
    b. Essential Health Benefits
    c. Actuarial Value of Benefits (Minimum value)
    d. Others – please list.

6. Will you provide a Summary of Benefits and Coverage?

7. How will you assist the School District in understanding the fees associated with the PPACA?

8. If applicable, how you will assess the fees, specifically, the Insurer fee, the PCOR fee and Transitional Reinsurance Program fee? Will these fees be assessed back to the School District?

9. What reporting will you provide or assist the School District with for the PPACA fees?

10. Are sample summary plan documents and other benefits plan descriptions and riders provided for analysis?

11. Will you assure that your takeover of administration of the plan from the current insurer will be on a no loss/no gain basis to participants and the School District?

12. Do you agree that coverage is to be provided to those that meet the School District's eligibility requirements?

13. Do you agree to cover all presently insured employees, retirees and dependents whether at work, disabled or otherwise on approved absence on the effective date of coverage?

14. Will you be responsible for takeover of the current plan's extension of benefits? Explain.

15. With regard to transition of care, how will employees under the care of a physician or specialist for a serious health condition be notified?

16. What steps will be taken to assure continuation of quality care that transition of care patients require?

17. Please explain how you will assure that a key member of your service team will participate in any transition of care situation. Describe the team member's role and responsibilities.

18. How is lab work covered if performed in a physician's office? Is a specific lab company required to be used by members?

19. How is lab work covered if performed in an outside lab? Is a specific lab company required to be used by members?

20. **RAP BENEFITS:** The School District's plan offers both in-network and out-of-network benefits. For provider services for Radiologists, Anesthesiologists and Pathologists, if an employee/dependent/spouse has services done at an in-network facility, i.e. hospital or outpatient surgical center, etc., and there are ancillary services done as well, i.e. anesthesia, radiology, pathology, etc., the service is considered in-network with their current insurer. In this same example, if these provider services are completed and the service is considered out-of-network, how would the service be paid under your company? Please be specific and if there are limitations, please state if they are a plan requirement.

21. **PRE-AUTHORIZATION:** Explain how any pre-authorization program (medical and prescription) works for members and their dependents. What services need to have a pre-authorization? Who is responsible for pre-authorizations? How do members ensure that their services will be covered prior to a pre-authorized required service?

22. Explain the full claims decision appeals process for members and their dependents.

23. Briefly describe to what extent benefits are provided out of the local service area, e.g. if a participant (employee, retiree, COBRA or dependent) needs medical care elsewhere in the U.S. or abroad.

24. How are non-emergency services covered for participants who must travel for extended periods of time outside of their home location?

25. How do you propose to cover retirees whether they remain in the local area or move out of the area or out of state?

26. How do you cover dependents living out of the local service area for whom a participant has a legal responsibility (e.g. divorced spouse and/or child support) to provide medical coverage?

27. How do you cover dependent students living out of the local area?

28. What specific services or programs targeted at quality health care that are not addressed in the RFP do you offer that set you apart from your competitors? What do you do that is especially innovative?

PRESCRIPTION COVERAGE QUESTIONS

Attach necessary explanations and/or deviations.

1. Are you proposing to manage/administer prescription drug benefit equivalents to those currently offered?

2. For the HDHP/HSA plan offered, the drug costs can be very large for some employees. Explain if there are any programs that can assist an employee with pricing out prescription costs, etc.

3. Are you offering a generic listing of medications at no cost as currently provided to School District members? Are you able to offer any other programs that members can take advantage of? If there are any additional costs, explain.

4. Is your prescription drug formulary an open, closed or restricted formulary? Explain and give your definition of these terms.

5. How often are formulary changes allowed? What controls are there on balancing School District convenience with the frequency that formulary changes are made? How are members notified?

6. Have you enclosed a list of the prescription drugs your formulary includes?

7. In regards to mail order, are there any requirements for specific drugs to be filled only at mail order? If so, please explain and provide a list. The School District is concerned about mandatory mail order on specific drugs due to the cost for employees. Are there options that the School District can consider?

8. How do you report prior authorizations and pharmacy DUR overrides entered in your claims system?

9. How are physicians directed or otherwise influenced to write prescriptions from the formulary?

10. What is your expectation of the pharmacist, the physician, and the participant when a non-formulary prescription is written?

11. Describe any cost effective interventions that you recommend, e.g. prior authorizations, step therapies and quantity limits, and your rationale for adopting them. State which programs are mandatory and which ones are optional.

12. Explain in detail how you can assist the School District in identifying if any members are potential drug abusers and the tactics you provide to contact members and prescribing physicians to alter purchase behavior and prescribing patterns. Be certain to highlight any caveats or plan parameters you require, and if there are any additional costs for such service.

EMPLOYEE ASSISTANCE PROGRAM COVERAGE QUESTIONS

1. Is the EAP program severable from the medical program?

2. Are sample summary plan documents and other benefit plan descriptions provided for analysis?

3. Explain how the program can be utilized.

4. Are the visits per issue?

5. Explain the eligibility of the program and who can utilize the EAP program.

6. Describe if there are telephonic coaching sessions available and included in the cost of the EAP.

7. Have you provided descriptive material on all EAP benefits provided and all limitations and exclusions?

8. Will you be utilizing the services of subcontractors in rendering this service?

HRA/HSA COVERAGE QUESTIONS

Attach necessary explanations and/or deviations.

1. Are you agreeable to take over HRA (single) and/or HSA (family) administration? Are you able to offer both an HRA and HSA?

2. How is the claims payment process completed? Please outline the claims payment process.

3. How will the funding be transmitted?

4. Have you provided details about your plan to educate participation in the School District's health savings account?

5. Have you stated and provided samples with your proposal of the type of communications/enrollment system to be used for each benefit option?

6. Will you prior to solicitation of enrollment, provide communications materials to participants regarding options they may choose and the effect on their taxable income?

7. What is your most realistic estimate of the least number of calendar days required for the education phase and the enrollment of the School District's group?

8. State whether your service fees and/or other cost factors will be affected by the number of enrolled participants including any minimum costs and/or requirements.

9. List the optional methods you can offer participants for paying for services from their HSA account. Debit card is required. e.g. ID card, Check, ATM, etc.

10. Which financial institution do you use for debit card management?

11. Explain the full range of services available to the School District and your experience, expertise and data processing capability relative to the solicited services.

12. What hours will your service be available to employees by telephone?

13. Will participants have on-line access to information about their accounts? How do they establish an account?

14. Do you acknowledge that you shall be strictly prohibited from any sales or marketing efforts regarding insurance or other products? Do you agree that your involvement in marketing or sales activities of unauthorized (by the School District) products or services will result in termination of the contract and forfeiture of any fees payable by the School District?

15. Will you be utilizing the services of subcontractors in rendering this service? If so, it is required that you provide the details on whom and what services they perform.

MEDICAL PROVIDER/MANAGED CARE INFORMATION

1. Identify the name and address of the organization(s) providing the following services and their characteristics:

   a. Provider Network(s)
      Please list all provider networks that you are proposing.

      Organization: ____________________________________
      Contact: ____
      Phone: ____
      Address: ____

   b. Medical Case Management

      Organization: ____________________________________
      Contact: ____
      Phone: ____

Address: ____

c. Utilization Review

Organization: ________________________________
Contact: ____________________________________
Phone: _____________________________________
Address: ____________________________________

d. Pharmacy Benefit Manager

Organization: ________________________________
Contact: ____________________________________
Phone: _____________________________________
Address: ____________________________________

2. Have you compared your network with the School District's network providers (Exhibit 4, 1 tab, in Excel format) and submitted a network match-up for the top providers?

3. Have you provided descriptive materials of the plan offered, including a directory of network hospitals, physicians and specialists, locations and office hours of facilities and staff and arrangements for after hours or emergency services?

4. State the duration of your provider contracts. For example, if most are "evergreen" state so and define what you mean by "evergreen". For major providers, indicate which contracts are for one year only (and the anniversary date), and which contracts are for longer than one year (and the expiration date of such longer term contracts).

5. Are there any major hospital or provider care systems whose contracts are expiring within the plan year? How does your company handle the increasing instances of insurer and provider contract conflicts? What assurances can you provide the School District?

6. Will School District employees have access to network providers on a statewide basis? If No, explain why not.

7. Is provider network information available on the Internet? Yes___ No___

   If Yes, indicate website address ______________________________________
   What is the date of the current directory? _________________________________
   How often is the directory updated? ____________________________________

8. What is your procedure to address the need for a primary care provider or specialist who may not be in your network?

9. How do you achieve cost effectiveness through negotiations when plan participants utilize providers not in the network, and the charges are very substantial?

10. The following questions are about primary care physicians (PCPs).
    a. Do any of your proposed plans require the use of a primary care physician, with referrals required to see a specialist? Which plans?

    b. Describe in detail how the referral process works and when a referral is required.

    c. Do you allow patients to select their PCP?

    d. What percentage of your PCPs and other physicians are not accepting new patients? (Please specify by County)

    e. Are your PCPs and specialists subject to quality assurance and utilization reviews?

    f. If your company has a sub network of select physicians, summarize your company's selection criteria, e.g. board designations, efficiency of care, statistical evaluation.

    g. If your company has a sub network of select hospitals, summarize your company's selection criteria, e.g. board designations, efficiency of care, statistical evaluation.

11. respond appropriately for any additional hospitals.

a. Hendry:
Hospital #1: ______________________________________
Hospital #2: ______________________________________
Hospital #3: ______________________________________
Hospital #4: ______________________________________
Hospital #5: ______________________________________
b. Lee:
Hospital #1: ______________________________________
Hospital #2: ______________________________________
Hospital #3: ______________________________________
Hospital #4: ______________________________________
Hospital #5: ______________________________________

c. Palm Beach:
Hospital #1: ______________________________________
Hospital #2: ______________________________________
Hospital #3: ______________________________________
Hospital #4: ______________________________________
Hospital #5: ______________________________________

d. Charlotte:
Hospital #1: ______________________________________
Hospital #2: ______________________________________
Hospital #3: ______________________________________
Hospital #4: ______________________________________
Hospital #5: ______________________________________

e. Glades:

Hospital #1: ______________________________________

Hospital #2: ______________________________________

Hospital #3: ______________________________________

Hospital #4: ______________________________________

Hospital #5: ______________________________________

f. Highlands:

Hospital #1: ______________________________________

Hospital #2: ______________________________________

Hospital #3: ______________________________________

Hospital #4: ______________________________________

Hospital #5: ______________________________________

f. Collier:

Hospital #1: ______________________________________

Hospital #2: ______________________________________

Hospital #3: ______________________________________

Hospital #4: ______________________________________

Hospital #5: ______________________________________

12. Indicate the number of hospitals with the following services, by county.

Network Provider	Hendry	Lee	Palm Beach
Hospital with Trauma Unit			
Hospital with Obstetrical Services			
Hospital with Cardiac Unit			
Hospital with Ambulatory Surgical Unit			
Hospital with Psychiatric Services			
Hospital with Chemical Dependency Service			

Network Provider	Charlotte	Glades	Highlands
Hospital with Trauma Unit			
Hospital with Obstetrical Services			
Hospital with Cardiac Unit			
Hospital with Ambulatory Surgical Unit			
Hospital with Psychiatric Services			
Hospital with Chemical Dependency Service			

Network Provider	Collier
Hospital with Trauma Unit	
Hospital with Obstetrical Services	
Hospital with Cardiac Unit	
Hospital with Ambulatory Surgical Unit	

Hospital with Psychiatric Services	
Hospital with Chemical Dependency Service	

13. PPO and High Deductible Options – Attach a listing of current network providers, including pharmacies and hospitals in Hendry, Lee, Palm Beach, Charlotte, Glades, Highlands and Collier Counties. Additionally, indicate on these listings those providers who are not accepting new patients. *These listings should include provider's address (street and city) and category of practice.*

14. Please provide the number of physicians in each of the following counties in the following specialties: (Count each physician once based on their primary practice.)

	Hendry – For each plan			**Lee – For each plan**		
	Total # Drs.	**# Board Certified**	**Accepts New Pts.**	**Total # Drs.**	**# Board Certified**	**Accepts New Pts.**
Family Practice						
General Practice						
Internal Medicine						
Obstetrics						
Pediatrics						
Gynecology						
General Surgery						
Cardiovascular Surgery						
Orthopedic Surgery						
Urology						
Psychiatry						
Nephrology						
Dermatology						
Gastroenterology						
Neurology						
Oncology						
Otolaryngology						
Ophthalmology						
Endocrinology						
Chiropractic						

	Palm Beach – For each plan			Charlotte – For each plan		
	Total # Drs.	**# Board Certified**	**Accepts New Pts.**	**Total # Drs.**	**# Board Certified**	**Accepts New Pts.**
Family Practice						
General Practice						
Internal Medicine						
Obstetrics						
Pediatrics						
Gynecology						
General Surgery						
Cardiovascular Surgery						
Orthopedic Surgery						
Urology						
Psychiatry						
Nephrology						
Dermatology						
Gastroenterology						
Neurology						
Oncology						
Otolaryngology						
Ophthalmology						
Endocrinology						
Chiropractic						

	Glades – For each plan			Highlands – For each plan		
	Total # Drs.	**# Board Certified**	**Accepts New Pts.**	**Total # Drs.**	**# Board Certified**	**Accepts New Pts.**
Family Practice						
General Practice						
Internal Medicine						
Obstetrics						
Pediatrics						
Gynecology						
General Surgery						
Cardiovascular Surgery						
Orthopedic Surgery						
Urology						
Psychiatry						
Nephrology						
Dermatology						
Gastroenterology						
Neurology						
Oncology						
Otolaryngology						
Ophthalmology						
Endocrinology						
Chiropractic						

	Collier – For each plan		
	Total # Drs.	# Board Certified	Accepts New Pts.
Family Practice			
General Practice			
Internal Medicine			
Obstetrics			
Pediatrics			
Gynecology			
General Surgery			
Cardiovascular Surgery			
Orthopedic Surgery			
Urology			
Psychiatry			
Nephrology			
Dermatology			
Gastroenterology			
Neurology			
Oncology			
Otolaryngology			
Ophthalmology			
Endocrinology			
Chiropractic			

PRESCRIPTION PROVIDER INFORMATION

Attach necessary explanations and/or deviations.

1. Have you provided a directory of network and other pharmacies, mail order services, etc.

2. Is your directory on the Internet?

3. How often is the directory updated?

4. Have you provided a list of participating pharmacies that include major retailers and local pharmacies in the School District's local area?

5. What major national or regional chains that are common sources of retail prescription drugs are not on your pharmacy list?

6. In regards to local pharmacies within the School District's immediate area, there is a concern that these pharmacies are not included in the participating pharmacy listing. Please provide a specific listing of the pharmacies in Hendry county (specifically within a 25 mile radius of zip codes 33935 and 33440). It is important that School District members be able to fill their prescriptions at the local pharmacies (non-national chain brand pharmacies).

7. Are there any major areas in Florida or nationally where there are few or no participating pharmacies?

EMPLOYEE ASSISTANCE PROGRAM PROVIDER INFORMATION

1. Have you provided a directory of your network of providers and the location(s) of the providers?

2. Please explain the referral process for when employees or their dependents have utilized the maximum number of EAP visits. How will the EAP network coordinate with District's medical insurer network for mental health and substance abuse counselors and other ongoing counseling issues?

MEDICAL SERVICE INFORMATION

Attach necessary explanations and/or deviations.

1. Indicate the name of the account representative that will service this account.

2. Where is the administration and claims payment facility located? ____

   a. If not local, can the School District contact the claims and/or administration departments by a toll-free number? Yes____ No_____

3. Please list (by person and title) of all personnel who will implement and manage all services of the account. Please provide copies of any implementation tools, such as an "Implementation Log" or "Implementation Schedule Timeline."

4. Will you require a new enrollment?

5. If so, what is your most realistic estimate of the least number of calendar days required to enroll the School District's group?

6. Will you provide representation for enrollment at each work location in sufficient numbers, as requested by the School District?

7. Do you agree to participate in the re-enrollment process, as needed, possibly by conducting employee orientation meetings, including explanation of the plan(s) offered, and key differences between current plans and those to be implemented?

8. Will you prepare literature describing the new plan in layman's terms and make such literature available for the employee meetings?

9. Will you provide an insurance policy/certificate/booklet, plan document, I.D. cards (coordinating with others to include pharmacy benefit information on a single card), and other appropriate literature to describe benefits to employees?

10. In addition, will you furnish an electronic version of the certificates/booklets for the School District to use on their website? Confirm these documents will be provided at no additional cost to the School District.

11. How will you coordinate with the School District to continue confirming enrollment/eligibility on a monthly basis by comparing the insurer's eligibility record to the School District's eligibility record in Excel format?

12. Will you offer online access for employees and dependents to review their medical claims, plan information, etc.? Explain.

13. To what extent do you recommend electronic enrollment? At what cost? Attach details.

14. What is your procedure and assistance for enrollment of employees who become eligible after plan inception?

15. Do you provide a 24-hour nurse "hot line" via a toll free number?

16. What service hours will you provide for the School District that will include time before and after the School District's normal work hours, and what access to service representatives will be available nights, weekends and holidays, if needed (describe your accommodations other than weekdays)?

17. Will you perform the following claims functions requested by the School District?

    a. Verify coverage and eligibility for benefits.
    b. Verify/confirm dependent eligibility.
    c. Make any necessary investigations or consultations with plan participants, medical care providers or others necessary to assure claim validity.
    d. Establish and maintain complete claims files on each claim.
    e. Coordinate with preferred providers, utilization review services and others who have an effect on claims activity.
    f. Properly review, process and pay claims.
    g. Provide direct payment to medical providers on assignment by participants.
    h. Coordinate benefits with all available sources, if not prohibited by law.
    i. Provide explanations of benefits (EOBs) to plan participants.
    j. Continuously advise with regard to actions, procedures, etc. which will result in control of claims and cost containment.

18. Do your provider contracts include a "hold harmless" clause to protect employees from any fees for provider services rendered that are eligible charges according to the plan (except deductible and coinsurance), regardless of the reason for non-payment? If yes, describe.

19. Do you assume fiduciary liability for administration of the plan? If yes, explain the process for settlement of a claim dispute. If not, explain both the financial and legal support that will be available to the School District.

20. What percentage of claims do you audit each month? Describe the audit process. Will you supply routine audit findings to the School District? Please provide a sample of this report.

21. Will your contract include a provision reserving the School District the right to audit claims at its expense, as the School District deems necessary?

22. Will you make all necessary records available for audit for up to three (3) years after the final year of your contract, and assist the School District regarding reconciliation of reports, if so requested?

23. Describe the instances in which an explanation of benefits (EOB) will be generated and forwarded to participants. Are EOBs in paper or electronic format, or both?

24. Will you perform all COBRA services needed by the School District? Explain if there are any COBRA related services you will not provide.

25. Will you administer HIPAA and assure compliance with HIPAA law?

26. Will any costs incurred at installation of your plan, be expected to be incurred by the School District? What costs and what amounts?

27. Are you providing any sort of installation allowance to financially aid the School District in getting through the installation?

28. Explain how your organization will coordinate with managed care network(s).

29. Describe your organization's method of data exchange and controls used to insure accurate transfer of data from utilization review and medical case management firm.

30. Have you provided an attachment of your performance guarantees? Are they specific to the School District? If not, why? What is your total/maximum at-risk amount?

31. Are you willing to negotiate alternative terms, and to recommend incentives and/or disincentives to make the performance guarantee(s) practical?

32. Will you permit the School District to perform audits regarding the performance guarantees?

33. Explain how your system identifies claims with medical case management potential.

34. Please confirm that you will provide the insurance coverage as described in Section II of the RFP. If there are any deviations, please state them here.

35. Identify below any additional information about your proposal that the School District should consider (*attach and identify additional pages as necessary*).

PRESCRIPTION SERVICE INFORMATION

Attach necessary explanations and/or deviations.

1. Indicate the name of the account representative that will service this account.

2. Can the School District contact the administration department by a toll free number? What is the number?

3. Have you provided details of the administration services proposed, and a description of experience, staffing, locations, computer capability, etc.?

4. State and define your expected mail order turnaround time for a prescription drug the first time it is requested as mail order.

5. State and define your expected specialty drug turnaround time and any other special instructions that have to be followed with specialty drug ordering.

HRA/HSA SERVICE INFORMATION

Attach necessary explanations and/or deviations.

1. Indicate the name of the account representative that will service this account.

2. Can the School District contact the administration department by a toll free number? What is the number?

3. How does the account team representing the HSA administration coordinate with the medical and prescription insurer? Explain the process of coordination. Is it seamless to the School District and what is the expected involvement of the School District?

4. Have you provided details of the HSA services proposed, and a description of experience, staffing, etc.?

5. What is your minimum lead time to set up the School District's account?

6. Please confirm that you will provide the insurance coverage as described in Section II, page 3 of the RFP. If there are any deviations, please state them here.

MEDICAL AND PRESCRIPTION REPORTING SERVICES

Attach necessary explanations and/or deviations.

1. Will you provide monthly summaries of enrollment, rates, premiums and claims, (within 30 days of the end of the month) with cumulative totals for the plan year? Explain any differences between what is requested and what you will provide.

2. Will you provide such information separately for employees and their dependents, retirees (Medicare and non-Medicare eligible) and their dependents, COBRA and their dependents, and total for all participants and all dependents?

3. Will you provide such claims reports additionally for 12 months after plan termination, or until there are no run-out claims? State the cost, if any.

4. Will you provide and update monthly information on claims over $50,000? State the cost, if any.

5. State specifically which of the following are automatically included in your proposed costs, and which are not. For reports not automatically provided, separately state the additional cost.
   a) Total charges by provider and for all physicians collectively, total charges by hospital and for all hospitals collectively, total charges for all prescriptions by pharmacy and for all pharmacies collectively. State the cost, if any.

   b) Number of hospital admissions, number of hospital days, and number of hospital days per admission by hospital and for all hospitals collectively. State the cost, if any.

   c) Total charges in network versus out-of-network, separately for physicians and for hospitals. State the cost, if any.

   d) Frequency and severity by diagnosis (provide the top 20). State the cost, if any.

   e) Estimated cost reductions produced by pre-certification/utilization review or other cost containment method. State the cost, if any.

   f) Total dollar recoveries from subrogation and coordination of benefits. State the cost, if any.

6. Please describe other claims reports formats and management reporting systems available to the School District. If there are any additional costs, please state.

7. Are you capable of modifying existing report formats to provide the premium/claims experience information desired by the School District?

8. Describe how the School District can have access to its data to produce reports on its own, and the support to be provided to assist the School District in doing so.

PRESCRIPTION REPORTING SERVICES

Attach necessary explanations and/or deviations.

1. Will you provide the School District with more detailed reports at least quarterly, and an annual report of claims for the policy year, within 30 days of the end of the quarter and policy year?

2. Describe the information and reports that the School District has access to via the web interface.

3. Describe the School District's participants' ability to access online information via web interface.

4. Will your reports provide details of brand (and preferred brand, where applicable) versus generic utilization, and will you proactively assist the School District in promoting increased use of generics if there is less utilization than should be expected?

5. Will your reports provide details of retail versus mail order utilization?

6. Please list the types of reports you can provide and provide examples.

7. Provide sample communication materials you have concerning:
   a) Formulary
   b) Medical conditions for which generic medications are available
   c) Merits of generic substitution
   d) Advantages of mail order service
   e) Step Therapy programs for specific drugs
   f) Any additional drug programs available

HRA/HSA SERVICE REPORTING SERVICES

Attach necessary explanations and/or deviations.

1. Will you prepare and mail quarterly individual account statements to participants?
2. Will you provide a biweekly participation and account status report to the School District?
3. Will you provide a summary Annual Report for employees?
4. Will you prepare an annual forfeiture report to the School District?
5. Will you fulfill federal report filing requirements, including issuing 1099s to providers?
6. Do you agree to the School District retaining property rights, for the School District's own use, to all materials, reports, produced by the administrator specifically for the School District?
7. What information do you need from the School District initially and on an ongoing basis as it pertains to file uploads?
8. Will you maintain books, records, documents, and evidence on costs and expenses for services provided?

WELLNESS/DISEASE MANAGEMENT

Attach necessary explanations and/or deviations.

1. Are you able to offer a program similar to the Better You Worksite Wellness program?

2. Does your proposal include any additional wellness benefits such as health screenings (i.e. skin cancer screening, vision screening, etc.), flu shot program and/or mini health fairs?

3. Does you proposal include an annual wellness incentive fund or similar program fund for the School District?

4. What incentives do you provide for complying with wellness initiatives? E.g., prevention screenings, reduction in premium for compliance, etc.

5. What type of return on investment should be expected from the wellness program you are proposing? How are you able to measure and demonstrate such a return?

6. What other services or programs do you offer that set you apart from your competitors? What do you do that is especially innovative?

7. Do you have experience either administering or participating in a health fair?

8. Does your proposal include any online and/or telephonic coaching services?

9. What extent of health coaching do you expect to provide, for what conditions?

10. Will an employee being health coached for a condition be able to talk to the same health coach each time, or will the employee have to take whatever health coach is available at the time?

11. Do you have any programs specifically designed for diabetes? Explain.

12. Do you have any programs specifically designed for allergies? Explain.

13. Do you have any programs specifically designed for high blood pressure? Explain.

14. Do you have any programs specifically designed for high cholesterol? Explain.

15. Do you have any programs specifically designed for weight loss? Explain.

16. Do you have ready-made programs for implementation, such as smoking cessation and nutrition?

17. What is your approach to the following items regarding disease management programs?
    a. Identifying persons at risk (i.e. Health Risk Assessment).
    b. Intervention and your basis for such.
    c. Educating targeted persons to take an active role in disease prevention/ management.
    d. Conduct of on-going (e.g. monthly) activities and programs to encourage continuous commitment by participants
    e. Coordination of providers and cost-efficiently maximizing their involvement.
    f. Management of chronic diseases.
    g. Measuring the results.

18. Which of the following diseases/conditions/procedures are targeted in your disease management program? Check in the column left of each item, if you are involved.

	Acid Related Disorders		High Cholesterol
	Allergies		Hypertension
	ALS (Amyotrophic Lateral Sclerosis)		Inflammatory Bowel Disease
	Arthritis (Rheumatoid)		Irritable Bowel Syndrome
	Asthma		Joint Pain
	Atrial Fibrillation		Kidney Disease (Chronic)
	Back pain		Lung disease (chronic obstructive)
	Cancer, incl breast, colon, prostate, skin		Lupus Erythematosis (Systemic)
	COPD		Maternity
	Congestive heart failure		Migraine
	Coronary artery disease		Multiple Sclerosis
	Crohn’s Disease		Musculoskeletal (excluding low back)
	Cystic Fibrosis		Myasthenia Gravis
	Depression		Osteoarthritis
	Dermatomyositis		Osteoporosis
	Diabetes		Parkinson’s Disease
	Fibromyalgia		Prostatic Hyperlasia (Benign)
	Gastroesophageal reflux		Renal Disease (End Stage)
	Gaucher Disease		Scleroderma
	Hemophilia		Seizure Disorders
	Hepatitus		Sickle Cell Anemia
	HIV		Transplants
	High Blood Pressure		Uterine Conditions (Benign)

19. Which of these diseases/conditions/procedures are prime targets in your involvement?

20. How do you plan to coordinate medical claims, pharmacy and other sources of data to maximize the effectiveness of the wellness program?

21. Do your disease management programs take into consideration care for males versus females, age differences, etc.?

22. What specific services or programs do you offer towards age-recommended testing (i.e. PSA tests, mammograms, etc.)?

23. What kind of credentials are held by the persons who are going to provide the basic wellness/disease management services you are proposing; e.g., will they include nurses, doctors, etc.?

24. What supplemental support for non-covered services can you make available? Do you have wellness items/services that are automatically included as part of your program, such as fitness club memberships, Nutri-System, discount bicycle helmets, Jenny Craig, Weight Watchers, etc.

25. What local partnerships can you help develop, e.g. discounts at local gyms, YMCA, YWCA, etc.

MEDICAL & PRESCRIPTION INSURER STABILITY

Attach necessary explanations and/or deviations.

1. Provide your current financial rating from A.M. Best and your current Financial Outlook.

Rating Firm	Rating
A.M. Best	______
Financial Outlook	______

2. Are you rated by NCQA? What is your rating?

3. Is the insurer authorized to do business in Florida?

4. Does your proposed program comply with all applicable Federal and Florida Statutes regarding group insurance, PPOs and HDHPs, and will you assure future compliance?

5. Briefly describe your organization and its history, number of years of providing services, legal structure, and ownership.

6. What year did the insurer begin business in Florida?

7. How many employees does your company have?

8. How many employees does your company have in Florida?

9. What comments can you offer in assurance of your financial stability and your long term commitment to the Florida market, especially with regard to School District and surrounding Counties?

HRA/HSA ADMINISTRATOR STABILITY

1. Is the administrator authorized to do business in Florida?

2. Does your proposed program comply with all applicable Federal and Florida Statutes regarding HSAs, and will you assure future compliance?

3. Briefly describe your organization and its history, number of years of providing services, legal structure, and ownership.

4. What year did the administrator begin business in Florida?

5. How many employees does your company have?

6. How many employees does your company have in Florida?

7. What comments can you offer in assurance of your financial stability and your long term commitment to the Florida market, especially with regard to School District and surrounding Counties?

MEDICAL & PRESCRIPTION CLIENT REFERENCES

1. Indicate the number of currently contracted employers in the State of Florida.

2. Indicate the number of currently contracted public-sector employers in the State of Florida.

3. List a minimum of four (4) current clients with similar size and/or industry as the School District with the following information:

    - Client Name
    - Contact Name and Title
    - Address
    - Phone and Fax
    - Email Address
    - Length of Client Relationship
    - State if a current or past client
    - Insurance Services Provided
    - Number of Employees

Please note: references must be specific to the proposed coverage(s) and/or service(s).

HRA/HSA CLIENT REFERENCES

1. Indicate the number of currently contracted employers in the State of Florida.

2. Indicate the number of currently contracted public-sector employers in the State of Florida.

3. List a minimum of four (4) current clients with similar size and/or industry as the School District with the following information:

    - Client Name
    - Contact Name and Title
    - Address
    - Phone and Fax
    - Email Address
    - Length of Client Relationship
    - State if a current or past client
    - Insurance Services Provided
    - Number of Employees

Please note: references must be specific to the proposed coverage(s) and/or service(s).

DEVIATIONS FROM MODEL PROGRAM

Indicate whether your proposal will or will not comply with the RFP with respect to the coverage, service or provision listed below. All endorsements set forth in the RFP are to be included VERBATIM in the contract unless indicated to the contrary on the Proposal Form. The absence of any notation will be presumed to indicate full compliance.

Section	RFP Provisions	Will	Will Not
II	Minimum Qualifications of Proposer		
II	Insurance Requirements		
II	Late Proposals, Late Modifications and Late Withdrawals		
II	Costs Incurred by Proposers		
II	Oral Presentation		
II	Exception to the RFP		
II	Proprietary Information		
II	Waiver/Rejection of Proposals		
II	Negotiations of Proposals		
II	Rules, Regulations and Licensing Requirement		
II	Records/Audit		
II	Investigation of Alleged Wrongdoings, Litigation/Settlement/Fines/Penalties		
II	Conduct of Proposers		
II	Conflict of Interest		
II	Legal Requirements		
II	Public Entity Crimes Statement		
II	Anti-Discrimination Clause		
II	Discriminatory Vendor's List		
II	State Licensing Requirement		
II	Drug Free Workplace		
II	Use of Proposal Forms		
II	Irrevocability of Proposal		
II	Contract Awards		
II	Agent/Broker Services		
II	Agent of Record		
II	Deviations from Model Program		
III	Prohibition of Warranty Endorsement		
III	Sole Agent Endorsement		
III	Hold Harmless/Indemnification Provision		
III	Termination and Non-Renewal Endorsement		
III	Rerating Endorsement		
IV	Contract Period		
IV	Rate Guarantee Period		
IV	Remuneration		
IV	Access to Claim Files		
IV	Ownership of Claim Data		
IV	Audit Requirement		
IV	Eligibility & Enrollment		
IV	Continuity of Coverage (No Loss/No Gain)		
IV	Scope of Coverage		

IV	Pooling Point		
IV	Scope of Services		
IV	Managed Care Services		
IV	Administrative Services		
IV	Healthcare Reform Services		
IV	Prescription Benefit Services		
IV	Employee Assistance Program Services		
IV	Health Savings Account Administration		
IV	Medical & Prescription Reporting & Data Services		
IV	Wellness Program and Disease Management Services		
IV	Performance Guarantees		

ADDITIONAL COMMENTS/DEVIATIONS FROM MODEL PROGRAM

If your proposal does not fully comply with any provision, condition or requirement in this RFP, explain fully (*attach and identify additional pages as necessary*) the alternative provision, condition or requirement proposed.

ACKNOWLEDGMENT OF RECEIPT OF ADDENDA

The Proposer hereby acknowledges receipt of the following addenda:

1. __________ 2. _______ 3. _______ 4. ________

CHECKLIST OF MATERIAL TO BE INCLUDED

The following material should be included as part of each of the completed responses to this RFP including: one (1) paper original and one (1) paper copy (total of two (2) paper proposals) and three (3) Thumb Drives (with all documents in their original format, Word, Excel, etc.)

1. Completed Proposal Forms, and specimen contracts or policies as described in this RFP.

2. Acknowledgment of any addenda.

3. Specimen copy or samples of the following:

   a. Benefit booklets
   b. Benefits Match-Up a,b,c Exhibit 3– In Word format
   c. Network provider (and pharmacy directories)
   d. Most Utilized Providers Exhibit 4– In Excel format
   e. Explanation of Benefits Statement
   f. ID cards and claim forms
   g. Claims and exposure report samples
   h. HSA reports

4. Descriptive literature on Utilization Management Services Program, Medical Case Management, Prescription Drug Program, Employee Assistance Program and HSA System/Capabilities.

5. Completion of financial ratings as outlined under "Medical and Prescription Insurer Stability" and "HSA Administrator Stability."

6. Information on experience and references as requested on Proposal Forms.

PROPOSER'S WARRANTY

The undersigned person, by the undersigned's signature affixed hereon, warrants that:

1. The undersigned is an officer, partner or a sole proprietor of the firm (insurer) and the enclosed proposal is submitted on behalf of the firm;

2. The undersigned has carefully reviewed all the materials and data provided on the insurer's proposal on behalf of the insurer, and, after specific inquiry, believes all the material and data to be true and correct;

3. The proposal offered by the insurer is in full compliance with the Minimum Qualifications of Proposer set forth in Section II of this RFP;

4. The insurer authorizes the School District, its staff or consultants to contact any of the references provided in the proposal and specifically authorizes such references to release either orally or in writing any appropriate data with respect to the insurer offering this proposal;

5. The undersigned has been specifically authorized to issue a contract in full compliance with all requirements and conditions, as set forth in this RFP, other than those deviations noted above;

6. If this proposal is accepted, the contract will be issued as proposed.

____

Name of Firm/Insurer

____

Signature of Authorized Representative

____

Printed Name of Authorized Representative

____

Title of Authorized Representative

____

Date Signed by Authorized Representative

SCHOOL DISTRICT OF HENDRY COUNTY

Section X

Proposal Forms for Medical Claims Administration Services

SECTION X

THE SCHOOL DISTRICT OF HENDRY COUNTY

MEDICAL CLAIMS ADMINISTRATION SERVICES

PROPOSAL FORMS

A. PROPOSER'S IDENTIFICATION

Name of Insurer: ______________________________

FEIN/SS#: ______________________________

Address: ______________________________

____

____

Insurer Proposal Contact: ______________________________

Telephone Numbers Daytime/After Hours: ______________________________

E-mail: ______________________________

B. IF APPLICABLE – INSURANCE AGENCY(IES)/AGENT(S)

NOTE: If one or more agencies/agents are acceptable to the proposing insurer, please list those firms and representatives which you approve, if the School District should decide on a proposal other than directly through the proposing insurer's employee agent:

	Agency	**Agent**
1.		
2.		
3.		

NOTE: If an agent(s) is/are listed, the Agents proposal forms at the end of this document, Section XII - Agent/Broker Services must be completed by each of such agent(s).

MEDICAL CLAIMS ADMINISTRATION COST INFORMATION

Administration costs for the three (3) self-insured plans based on per employee per month (PEPM) cost

Provide the monthly rates and annual cost in the table below if the rates are the same for the three (3) plans being offered. However, if the rates are different for the plans, create an additional table for each plan. Make sure that if you add one (1) or more tables to account for different rates that the total of all tables equals total annual cost for all plans.

	ADMINISTRATION COST FOR 1/1/2023-12/31/2023	#	X	$Rate	X	12	=	Annual Cost
1.	Claims service cost	982	X	$	X	12	=	$
2.	Network access fees, if any	982	X	$	X	12	=	$
3.	Wellness Program (attach explanation)	982	X	$	X	12	=	$
4.	COBRA administration cost *	982	X	$	X	12	=	$
5.	HIPAA administration cost	982	X	$	X	12	=	$
6.	Premium taxes	982	X	$	X	12	=	$
7.	Commissions, finders fees or other remuneration to insurance agent	982	X	$	X	12	=	$
8.	Enrollment meetings and materials	982	X	$	X	12	=	$
9.	Printing of booklets, plan documents	982	X	$	X	12	=	$
10.	Other charges (explain)	982	X	$	X	12	=	$
	TOTAL ADMINISTRATION COST							**$**

* Proposers should clearly state if COBRA services are to be provided by an outside firm, charging extra.

1. For how many years are these PEPM administration rates guaranteed? A minimum of three (3) years is preferred. Are there any assumptions, special requirements or contingencies involved?

2. Does your cost includes payment of run-out claims and extension of benefits claims of disabled persons (the School District is obligated to pay claims as required by Florida Statute 627.667 (3) (a) for up to 12 months after plan termination). If this cost is not included, provide the additional cost for such service.

3. Is agent/broker remuneration included in your fees or rates? Yes ____ No ____

4. Please indicate the manner in which agent/broker remuneration is calculated:

5. Please provide an estimate of the annual remuneration.

MEDICAL AND RX CLAIMS PROJECTIONS

PLAN 1________________(state plan name/#) CLAIMS PROJECTIONS (Plan most similar to Aetna MC Plan 1)	Next 12 Months
Estimate of 01/01/2023 – 12/31/2023 paid claims	$
Estimate of 01/01/2023 – 12/31/2023 incurred claims	$
Medical claims trend factor	1.

PLAN 2________________(state plan name/#) CLAIMS PROJECTIONS (Plan most similar to Aetna MC Plan 2)	Next 12 Months
Estimate of 01/01/2023 – 12/31/2023 paid claims	$
Estimate of 01/01/2023 – 12/31/2023 incurred claims	$
Medical claims trend factor	1.

PLAN 3________________(state plan name/#) CLAIMS PROJECTIONS (Plan most similar to Aetna MC Plan 3 HRA/HSA)	Next 12 Months
Estimate of 01/01/2023 – 12/31/2023 paid claims	$
Estimate of 01/01/2023 – 12/31/2023 incurred claims	$
Medical claims trend factor	1.

TOTAL CLAIMS PROJECTIONS	Next 12 Months
Estimate of 01/01/2023 – 12/31/2023 paid claims	$
Estimate of 01/01/2023 – 12/31/2023 incurred claims	$

MEDICAL CLAIMS ADMINISTRATION COST INFORMATION

Attach necessary explanations and/or deviations.

1. What is the range of required enrollment for each option offered? State here if there are any required minimums.

2. For what range of employees and retirees are the proposed costs applicable (e.g., within 5%, 10%, etc. of the census)

3. If the number of enrollees is less than the plan members in the census data, but the age and sex mix are not materially different, will you honor your proposal as proposed?

4. What rate/cost guarantees will you provide beyond the first twelve (12) months, e.g., administration or other? Provide details.

5. Will you agree to negotiate changes in proposed benefits, administration and other costs, if the School District should desire to do so?

6. Are there any subrogation fees? Explain.

Network Cost Questions

1. Identify average medical network provider discounts in the following counties for the plans you are proposing:

Hendry County

	Discount off billed charges	Explanation
PPO Physicians		
HDHP Physicians		
PPO Hospitals		
HDHP Hospitals		

Lee County

	Discount off billed charges	Explanation
PPO Physicians		
HDHP Physicians		
PPO Hospitals		
HDHP Hospitals		

Palm Beach County

	Discount off billed charges	Explanation
PPO Physicians		
HDHP Physicians		
PPO Hospitals		
HDHP Hospitals		

Charlotte County

	Discount off billed charges	Explanation
PPO Physicians		
HDHP Physicians		
PPO Hospitals		
HDHP Hospitals		

Glades County

	Discount off billed charges	Explanation
PPO Physicians		
HDHP Physicians		
PPO Hospitals		
HDHP Hospitals		

Highlands County

	Discount off billed charges	Explanation
PPO Physicians		
HDHP Physicians		
PPO Hospitals		
HDHP Hospitals		

Collier County

	Discount off billed charges	Explanation
PPO Physicians		
HDHP Physicians		
PPO Hospitals		
HDHP Hospitals		

2. Are you providing any guaranteed network discounts for the School District? If yes, describe in detail.

3. If providing any guaranteed network discounts, are there any claim exclusions from these discounts?

4. Describe the verification process of the network discounts proposed.

5. Is a specific lab company required to be used by members? Describe your contracted arrangements for laboratory work. Is the lab arrangement capitated? Describe the discounts and terms.

EMPLOYEE ASSISTANCE PROGRAM COST QUESTIONS

1. What are the proposed costs for the EAP services and for how many visits?

2. Are there any cost guarantees? For how many months?

3. Are there any additional costs for any of the requested services? Explain and provide details.

PRESCRIPTION COST QUESTIONS

Attach necessary explanations and/or deviations.

1. For the School District's size and medical and prescription experience, what would you recommend to the School District to control escalating prescription costs?

2. Please describe any generic prescriptions available to members at a reduced or zero cost share. Are you able to match the current "Free Preventative Medications" and "Free Preventative Generic Medications" lists?

3. What additional programs can the School District consider for prescriptions? I.e. 90-day retail option, generic usage program, step therapy, etc. Please note the current programs they are participating in and also describe the options available and if there are any additional costs.

4. Provide your recommendations on how to improve generic utilization. Explain.

5. Is the mail order pharmacy owned by the proposing company or is it outsourced? If outsourced, to which mail order pharmacy company and why? Explain the benefits of this mail order service.

6. What incentives do you recommend to encourage participants to use the mail order service?

7. What controls do you recommend to minimize over-utilization and/or fraud in connection with the mail order service?

8. Is the specialty pharmacy owned by the proposing company or is it outsourced? If outsourced, to which specialty pharmacy company and why? Explain the benefits of this specialty pharmacy.

9. What initiatives do you employ against other types of claims fraud and are there any additional costs for these initiatives?

10. Describe the extent to which you perform any screening to detect possible multiple drug interactions/reactions and your procedure for notifying participants.

MEDICAL AND PRESCRIPTION COVERAGE QUESTIONS

Attach necessary explanations and/or deviations.

1. Have you provided the Benefits Match-up a,b,c (Exhibit 3 in Word format)?

2. Are the plans proposed file and approved with the State of Florida for 1/1/2023? If not, explain.

3. Have you provided descriptive material on all medical benefits provided and all limitations and exclusions?

4. Will you provide ongoing PPACA (Healthcare Reform) guidance, updates and resources? Explain.

5. How will you assist the School District in remaining in compliance with the PPACA, specifically with:
    - e. Guaranteed Availability of Coverage
    - f. Essential Health Benefits
    - g. Actuarial Value of Benefits (Minimum value)
    - h. Others – please list.

6. Will you provide a Summary of Benefits and Coverage?

7. How will you assist the School District in understanding the fees associated with the PPACA?

8. If applicable, how you will assess the fees, specifically, the Insurer fee, the PCOR fee and Transitional Reinsurance Program fee? Will these fees be assessed back to the School District?

9. What reporting will you provide or assist the School District with for the PPACA fees?

10. Are sample summary plan documents and other benefits plan descriptions and riders provided for analysis?

11. Will you assure that your takeover of administration of the plan from the current insurer will be on a no loss/no gain basis to participants and the School District?

12. Do you agree that coverage is to be provided to those that meet the School District's eligibility requirements?

13. Do you agree to cover all presently insured employees, retirees and dependents whether at work, disabled or otherwise on approved absence on the effective date of coverage?

14. Will you be responsible for takeover of the current plan's extension of benefits? Explain.

15. With regard to transition of care, how will employees under the care of a physician or specialist for a serious health condition be notified?

16. What steps will be taken to assure continuation of quality care that transition of care patients require?

17. Please explain how you will assure that a key member of your service team will participate in any transition of care situation. Describe the team member's role and responsibilities.

18. How is lab work covered if performed in a physician's office? Is a specific lab company required to be used by members?

19. How is lab work covered if performed in an outside lab? Is a specific lab company required to be used by members?

20. **RAP BENEFITS:** The School District's plan offers both in-network and out-of-network benefits. For provider services for Radiologists, Anesthesiologists and Pathologists, if an employee/dependent/spouse has services done at an in-network facility, i.e. hospital or outpatient surgical center, etc., and there are ancillary services done as well, i.e. anesthesia, radiology, pathology, etc., the service is considered in-network with their current insurer. In this same example, if these provider services are completed and the service is considered out-of-network, how would the service be paid under your company? Please be specific and if there are limitations, please state if they are a plan requirement.

21. **PRE-AUTHORIZATION:** Explain how any pre-authorization program (medical and prescription) works for members and their dependents. What services need to have a pre-authorization? Who is responsible for pre-authorizations? How do members ensure that their services will be covered prior to a pre-authorized required service?

22. Explain the full claims decision appeals process for members and their dependents.

23. Briefly describe to what extent benefits are provided out of the local service area, e.g. if a participant (employee, retiree, COBRA or dependent) needs medical care elsewhere in the U.S. or abroad.

24. How are non-emergency services covered for participants who must travel for extended periods of time outside of their home location?

25. How do you propose to cover retirees whether they remain in the local area or move out of the area or out of state?

26. How do you cover dependents living out of the local service area for whom a participant has a legal responsibility (e.g. divorced spouse and/or child support) to provide medical coverage?

27. How do you cover dependent students living out of the local area?

28. What specific services or programs targeted at quality health care that are not addressed in the RFP do you offer that set you apart from your competitors? What do you do that is especially innovative?

EMPLOYEE ASSISTANCE PROGRAM COVERAGE QUESTIONS

1. Is the EAP program severable from the medical program?

2. Are sample summary plan documents and other benefit plan descriptions provided for analysis?

3. Explain how the program can be utilized.

4. Are the visits per issue?

5. Explain the eligibility of the program and who can utilize the EAP program.

6. Describe if there are telephonic coaching sessions available and included in the cost of the EAP.

7. Have you provided descriptive material on all EAP benefits provided and all limitations and exclusions?

8. Will you be utilizing the services of subcontractors in rendering this service?

PRESCRIPTION COVERAGE QUESTIONS

Attach necessary explanations and/or deviations.

9. Are you proposing to manage/administer prescription drug benefit equivalents to those currently offered?

10. For the HDHP/HSA plan offered, the drug costs can be very large for some employees. Explain if there are any programs that can assist an employee with pricing out prescription costs, etc.

11. Are you offering a generic listing of medications at no cost as currently provided to School District members? Are you able to offer any other programs that members can take advantage of? If there are any additional costs, explain.

12. Is your prescription drug formulary an open, closed or restricted formulary? Explain and give your definition of these terms.

13. How often are formulary changes allowed? What controls are there on balancing School District convenience with the frequency that formulary changes are made? How are members notified?

14. Have you enclosed a list of the prescription drugs your formulary includes?

15. In regards to mail order, are there any requirements for specific drugs to be filled only at mail order? If so, please explain and provide a list. The School District is concerned about mandatory mail order on specific drugs due to the cost for employees. Are there options that the School District can consider?

16. How do you report prior authorizations and pharmacy DUR overrides entered in your claims system?

17. How are physicians directed or otherwise influenced to write prescriptions from the formulary?

18. What is your expectation of the pharmacist, the physician, and the participant when a non-formulary prescription is written?

19. Describe any cost effective interventions that you recommend, e.g. prior authorizations, step therapies and quantity limits, and your rationale for adopting them. State which programs are mandatory and which ones are optional.

HRA/HSA COVERAGE QUESTIONS

Attach necessary explanations and/or deviations.

1. Are you agreeable to take over HRA (single) and/or HSA (family) administration? Are you able to offer both an HRA and HSA?

2. How is the claims payment process completed? Please outline the claims payment process.

3. How will the funding be transmitted?

4. Have you provided details about your plan to educate participation in the School District's health savings account?

5. Have you stated and provided samples with your proposal of the type of communications/enrollment system to be used for each benefit option?

6. Will you prior to solicitation of enrollment, provide communications materials to participants regarding options they may choose and the effect on their taxable income?

7. What is your most realistic estimate of the least number of calendar days required for the education phase and the enrollment of the School District's group?

8. State whether your service fees and/or other cost factors will be affected by the number of enrolled participants including any minimum costs and/or requirements.

9. List the optional methods you can offer participants for paying for services from their HSA account. Debit card is required. e.g. ID card, Check, ATM, etc.

10. Which financial institution do you use for debit card management?

11. Explain the full range of services available to the School District and your experience, expertise and data processing capability relative to the solicited services.

12. What hours will your service be available to employees by telephone?

13. Will participants have on-line access to information about their accounts? How do they establish an account?

14. Do you acknowledge that you shall be strictly prohibited from any sales or marketing efforts regarding insurance or other products? Do you agree that your involvement in marketing or sales activities of unauthorized (by the School District) products or services will result in termination of the contract and forfeiture of any fees payable by the School District?

MEDICAL CLAIMS ADMINISTRATION PROVIDER/MANAGED CARE INFORMATION

1. Identify the name and address of the organization(s) providing the following services and their characteristics:

    a. Provider Network(s)
    Please list all provider networks that you are proposing.

    Organization: ________________________________
    Contact: ________________________________
    Phone: ________________________________
    Address: ________________________________

    b. Medical Case Management

    Organization: ________________________________
    Contact: ________________________________
    Phone: ________________________________
    Address: ________________________________

    c. Utilization Review

    Organization: ________________________________
    Contact: ________________________________
    Phone: ________________________________
    Address: ________________________________

    d. Pharmacy Benefit Manager

    Organization: ________________________________
    Contact: ________________________________
    Phone: ________________________________
    Address: ________________________________

2. Have you compared your network with the School District's network providers (Exhibit 4, 1 tab, in Excel format) and submitted a network match-up for the top providers?

3. Have you provided descriptive materials of the plan offered, including a directory of network hospitals, physicians and specialists, locations and office hours of facilities and staff and arrangements for after hours or emergency services?

4. State the duration of your provider contracts. For example, if most are "evergreen" state so and define what you mean by "evergreen". For major providers, indicate which contracts are for one year only (and the anniversary date), and which contracts are for longer than one year (and the expiration date of such longer term contracts).

5. Are there any major hospital or provider care systems whose contracts are expiring within the plan year? How does your company handle the increasing instances of insurer and provider contract conflicts? What assurances can you provide the School District?

6. Will School District employees have access to network providers on a statewide basis? If No, explain why not.

7. Is provider network information available on the Internet? Yes___ No___

   If Yes, indicate website address ____
   What is the date of the current directory? ___________________________________
   How often is the directory updated? ____

8. What is your procedure to address the need for a primary care provider or specialist who may not be in your network?

9. How do you achieve cost effectiveness through negotiations when plan participants utilize providers not in the network, and the charges are very substantial?

10. The following questions are about primary care physicians (PCPs).
    a. Do any of your proposed plans require the use of a primary care physician, with referrals required to see a specialist? Which plans?

    b. Describe in detail how the referral process works and when a referral is required.

    c. Do you allow patients to select their PCP?

    d. What percentage of your PCPs and other physicians are not accepting new patients? (Please specify by County)

    e. Are your PCPs and specialists subject to quality assurance and utilization reviews?

    f. If your company has a sub network of select physicians, summarize your company's selection criteria, e.g. board designations, efficiency of care, statistical evaluation.

g. If your company has a sub network of select <u>hospitals</u>, summarize your company's selection criteria, e.g. board designations, efficiency of care, statistical evaluation.

11. Respond appropriately for any additional hospitals.

a. <u>Hendry</u>:
Hospital #1: ______________________________
Hospital #2: ______________________________
Hospital #3: ______________________________
Hospital #4: ______________________________
Hospital #5: ______________________________

b. <u>Lee</u>:
Hospital #1: ______________________________
Hospital #2: ______________________________
Hospital #3: ______________________________
Hospital #4: ______________________________
Hospital #5: ______________________________

c. <u>Palm Beach</u>:
Hospital #1: ______________________________
Hospital #2: ______________________________
Hospital #3: ______________________________
Hospital #4: ______________________________
Hospital #5: ______________________________

d. <u>Charlotte</u>:
Hospital #1: ______________________________
Hospital #2: ______________________________
Hospital #3: ______________________________
Hospital #4: ______________________________
Hospital #5: ______________________________

e. <u>Glades</u>:
Hospital #1: ______________________________
Hospital #2: ______________________________
Hospital #3: ______________________________
Hospital #4: ______________________________
Hospital #5: ______________________________

f. <u>Highlands</u>:
Hospital #1: ______________________________
Hospital #2: ______________________________
Hospital #3: ______________________________
Hospital #4: ______________________________
Hospital #5: ______________________________

g. Collier:
Hospital #1: ____
Hospital #2: ____
Hospital #3: ____
Hospital #4: ____
Hospital #5: ____

12. Indicate the number of hospitals with the following services, by county.

Network Provider	Hendry	Lee	Palm Beach
Hospital with Trauma Unit			
Hospital with Obstetrical Services			
Hospital with Cardiac Unit			
Hospital with Ambulatory Surgical Unit			
Hospital with Psychiatric Services			
Hospital with Chemical Dependency Service			

Network Provider	Charlotte	Glades	Highlands
Hospital with Trauma Unit			
Hospital with Obstetrical Services			
Hospital with Cardiac Unit			
Hospital with Ambulatory Surgical Unit			
Hospital with Psychiatric Services			
Hospital with Chemical Dependency Service			

Network Provider	Collier
Hospital with Trauma Unit	
Hospital with Obstetrical Services	
Hospital with Cardiac Unit	
Hospital with Ambulatory Surgical Unit	
Hospital with Psychiatric Services	
Hospital with Chemical Dependency Service	

13. PPO and High Deductible Options – Attach a listing of current network providers, including pharmacies and hospitals in Hendry, Lee, Palm Beach, Charlotte, Glades, Highlands and Collier Counties. Additionally, indicate on these listings those providers who are not accepting new patients. *These listings should include provider's address (street and city) and category of practice.*

    1. Please provide the number of physicians in each of the following counties in the following specialties: (Count each physician once based on their primary practice.)

	Hendry			Lee		
	Total # Drs.	**# Board Certified**	**Accepts New Pts.**	**Total # Drs.**	**# Board Certified**	**Accepts New Pts.**
Family Practice						
General Practice						
Internal Medicine						
Obstetrics						
Pediatrics						
Gynecology						
General Surgery						
Cardiovascular Surgery						
Orthopedic Surgery						
Urology						
Psychiatry						
Nephrology						
Dermatology						
Gastroenterology						
Neurology						
Oncology						
Otolaryngology						
Ophthalmology						
Endocrinology						
Chiropractic						

	Palm Beach			Charlotte		
	Total # Drs.	**# Board Certified**	**Accepts New Pts.**	**Total # Drs.**	**# Board Certified**	**Accepts New Pts.**
Family Practice						
General Practice						
Internal Medicine						
Obstetrics						
Pediatrics						
Gynecology						
General Surgery						
Cardiovascular Surgery						
Orthopedic Surgery						
Urology						
Psychiatry						
Nephrology						
Dermatology						
Gastroenterology						
Neurology						
Oncology						
Otolaryngology						
Ophthalmology						
Endocrinology						
Chiropractic						

	Glades			Highlands		
	Total # Drs.	**# Board Certified**	**Accepts New Pts.**	**Total # Drs.**	**# Board Certified**	**Accepts New Pts.**
Family Practice						
General Practice						
Internal Medicine						
Obstetrics						
Pediatrics						
Gynecology						
General Surgery						
Cardiovascular Surgery						
Orthopedic Surgery						
Urology						
Psychiatry						
Nephrology						
Dermatology						
Gastroenterology						
Neurology						
Oncology						
Otolaryngology						
Ophthalmology						
Endocrinology						
Chiropractic						

	Collier		
	Total # Drs.	**# Board Certified**	**Accepts New Pts.**
Family Practice			
General Practice			
Internal Medicine			
Obstetrics			
Pediatrics			
Gynecology			
General Surgery			
Cardiovascular Surgery			
Orthopedic Surgery			
Urology			
Psychiatry			
Nephrology			
Dermatology			
Gastroenterology			
Neurology			
Oncology			
Otolaryngology			
Ophthalmology			
Endocrinology			
Chiropractic			

PRESCRIPTION ADMINISTRATOR INFORMATION

Attach necessary explanations and/or deviations.

1. Have you provided a directory of network and other pharmacies, mail order services, etc.

2. Is your directory on the Internet?

3. How often is the directory updated?

4. Have you provided a list of participating pharmacies that include major retailers and local pharmacies in the School District's local area?

5. What major national or regional chains that are common sources of retail prescription drugs are not on your pharmacy list?

6. In regards to local pharmacies within the School District’s immediate area, there is a concern that these pharmacies are not included in the participating pharmacy listing. Please provide a specific listing of the pharmacies in Hendry county (specifically within a 25 mile radius of zip codes 33935 and 33440). It is important that School District members be able to fill their prescriptions at the local pharmacies (non-national chain brand pharmacies).

7. Are there any major areas in Florida or nationally where there are few or no participating pharmacies?

EMPLOYEE ASSISTANCE PROGRAM PROVIDER INFORMATION

1. Have you provided a directory of your network of providers and the location(s) of the providers?

2. Please explain the referral process for when employees or their dependents have utilized the maximum number of EAP visits. How will the EAP network coordinate with District’s medical insurer network for mental health and substance abuse counselors and other ongoing counseling issues?

MEDICAL SERVICE INFORMATION

Attach necessary explanations and/or deviations.

1. Indicate the name of the account representative that will service this account.

2. Where is the administration and claims payment facility located?___________

3. If not local, can the School District contact the claims and/or administration departments by a toll-free number? Yes No_____

4. Please list (by person and title) of all personnel who will implement and manage all services of the account. Please provide copies of any implementation tools, such as an "Implementation Log" or "Implementation Schedule Timeline."

5. Will you require a new enrollment?

6. If so, what is your most realistic estimate of the least number of calendar days required to enroll the School District's group?

7. Will you provide representation for enrollment at each work location in sufficient numbers, as requested by the School District?

8. Do you agree to participate in the re-enrollment process, as needed, possibly by conducting employee orientation meetings, including explanation of the plan(s) offered, and key differences between current plans and those to be implemented?

9. Will you prepare literature describing the new plan in layman's terms and make such literature available for the employee meetings?

10. Will you provide an insurance policy/certificate/booklet, plan document, I.D. cards (coordinating with others to include pharmacy benefit information on a single card), and other appropriate literature to describe benefits to employees?

11. In addition, will you furnish an electronic version of the certificates/booklets for the School District to use on their website? Confirm these documents will be provided at no additional cost to the School District.

12. How will you coordinate with the School District to continue confirming enrollment/eligibility on a monthly basis by comparing the insurer's eligibility record to the School District's eligibility record in Excel format?

13. Will you offer online access for employees and dependents to review their medical claims, plan information, etc.? Explain.

14. To what extent do you recommend electronic enrollment? At what cost? Attach details.

15. What is your procedure and assistance for enrollment of employees who become eligible after plan inception?

16. Do you provide a 24-hour nurse "hot line" via a toll free number?

17. What service hours will you provide for the School District that will include time before and after the School District's normal work hours, and what access to service representatives will be available nights, weekends and holidays, if needed (describe your accommodations other than weekdays)?

18. Will you perform the following claims functions requested by the School District?

    a. Verify coverage and eligibility for benefits.

    b. Verify/confirm dependent eligibility.

    c. Make any necessary investigations or consultations with plan participants, medical care providers or others necessary to assure claim validity.

    d. Establish and maintain complete claims files on each claim.

    e. Coordinate with preferred providers, utilization review services and others who have an effect on claims activity.

    f. Properly review, process and pay claims.

    g. Provide direct payment to medical providers on assignment by participants.

    h. Coordinate benefits with all available sources, if not prohibited by law.

    i. Provide explanations of benefits (EOBs) to plan participants.

    j. Continuously advise with regard to actions, procedures, etc. which will result in control of claims and cost containment.

19. Do your provider contracts include a "hold harmless" clause to protect employees from any fees for provider services rendered that are eligible charges according to the plan (except deductible and coinsurance), regardless of the reason for non-payment? If yes, describe.

20. Do you assume fiduciary liability for administration of the plan? If yes, explain the process for settlement of a claim dispute. If not, explain both the financial and legal support that will be available to the School District.

21. What percentage of claims do you audit each month? Describe the audit process. Will you supply routine audit findings to the School District? Please provide a sample of this report.

22. Will your contract include a provision reserving the School District the right to audit claims at its expense, as the School District deems necessary?

23. Will you make all necessary records available for audit for up to three (3) years after the final year of your contract, and assist the School District regarding reconciliation of reports, if so requested?

24. Describe the instances in which an explanation of benefits (EOB) will be generated and forwarded to participants. Are EOBs in paper or electronic format, or both?

25. Will you perform all COBRA services needed by the School District? Explain if there are any COBRA related services you will not provide.

26. Will you administer HIPAA and assure compliance with HIPAA law?

27. Will any costs incurred at installation of your plan, be expected to be incurred by the School District? What costs and what amounts?

28. Are you providing any sort of installation allowance to financially aid the School District in getting through the installation?

29. Explain how your organization will coordinate with managed care network(s).

30. Describe your organization's method of data exchange and controls used to insure accurate transfer of data from utilization review and medical case management firm.

31. Have you provided an attachment of your performance guarantees? Are they specific to the School District? If not, why? What is your total/maximum at-risk amount?

32. Are you willing to negotiate alternative terms, and to recommend incentives and/or disincentives to make the performance guarantee(s) practical?

33. Will you permit the School District to perform audits regarding the performance guarantees?

34. Explain how your system identifies claims with medical case management potential.

35. Please confirm that you will provide the insurance coverage as described in Section II of the RFP. If there are any deviations, please state them here.

36. Identify below any additional information about your proposal that the School District should consider (attach and identify additional pages as necessary).

PRESCRIPTION SERVICE INFORMATION

Attach necessary explanations and/or deviations.

1. Indicate the name of the account representative that will service this account.

2. Can the School District contact the administration department by a toll free number? What is the number?

3. Have you provided details of the administration services proposed, and a description of experience, staffing, locations, computer capability, etc.?

4. State and define your expected mail order turnaround time for a prescription drug the first time it is requested as mail order.

5. State and define your expected specialty drug turnaround time and any other special instructions that have to be followed with specialty drug ordering.

HRA/HSA SERVICE INFORMATION

Attach necessary explanations and/or deviations.

1. Indicate the name of the account representative that will service this account.

2. Can the School District contact the administration department by a toll free number? What is the number?

3. How does the account team representing the HSA administration coordinate with the medical and prescription insurer? Explain the process of coordination. Is it seamless to the School District and what is the expected involvement of the School District?

4. Have you provided details of the HSA services proposed, and a description of experience, staffing, etc.?

5. What is your minimum lead time to set up the School District's account?

6. Please confirm that you will provide the insurance coverage as described in Section II, page 3 of the RFP. If there are any deviations, please state them here.

MEDICAL AND PRESCRIPTION REPORTING SERVICES

Attach necessary explanations and/or deviations.

1. Will you provide monthly summaries of enrollment, rates, premiums and claims, (within 30 days of the end of the month) with cumulative totals for the plan year? Explain any differences between what is requested and what you will provide.

2. Will you provide such information separately for employees and their dependents, retirees (Medicare and non-Medicare eligible) and their dependents, COBRA and their dependents, and total for all participants and all dependents?

3. Will you provide such claims reports additionally for 12 months after plan termination, or until there are no run-out claims? State the cost, if any.

4. Will you provide and update monthly information on claims over $50,000? State the cost, if any.

5. State specifically which of the following are automatically included in your proposed costs, and which are not. For reports not automatically provided, separately state the additional cost.

    a) Total charges by provider and for all physicians collectively, total charges by hospital and for all hospitals collectively, total charges for all prescriptions by pharmacy and for all pharmacies collectively. State the cost, if any.

    b) Number of hospital admissions, number of hospital days, and number of hospital days per admission by hospital and for all hospitals collectively. State the cost, if any.

    c) Total charges in network versus out-of-network, separately for physicians and for hospitals. State the cost, if any.

    d) Frequency and severity by diagnosis (provide the top 20). State the cost, if any.

    e) Estimated cost reductions produced by pre-certification/utilization review or other cost containment method. State the cost, if any.

    f) Total dollar recoveries from subrogation and coordination of benefits. State the cost, if any.

6. Please describe other claims reports formats and management reporting systems available to the School District. If there are any additional costs, please state.

7. Are you capable of modifying existing report formats to provide the premium/claims experience information desired by the School District?

8. Describe how the School District can have access to its data to produce reports on its own, and the support to be provided to assist the School District in doing so.

PRESCRIPTION REPORTING SERVICES

Attach necessary explanations and/or deviations.

1. Will you provide the School District with more detailed reports at least quarterly, and an annual report of claims for the policy year, within 30 days of the end of the quarter and policy year?

2. Describe the information and reports that the School District has access to via the web interface.

3. Describe the School District's participants' ability to access online information via web interface.

4. Will your reports provide details of brand (and preferred brand, where applicable) versus generic utilization, and will you proactively assist the School District in promoting increased use of generics if there is less utilization than should be expected?

5. Will your reports provide details of retail versus mail order utilization?

6. Please list the types of reports you can provide and provide examples.

7. Provide sample communication materials you have concerning:
    a) Formulary
    b) Medical conditions for which generic medications are available
    c) Merits of generic substitution
    d) Advantages of mail order service
    e) Step Therapy programs for specific drugs
    f) Any additional drug programs available

HRA/HSA SERVICE REPORTING SERVICES

Attach necessary explanations and/or deviations.

1. Will you prepare and mail quarterly individual account statements to participants?

2. Will you provide a biweekly participation and account status report to the School District?

3. Will you provide a summary Annual Report for employees?

4. Will you prepare an annual forfeiture report to the School District?

5. Will you fulfill federal report filing requirements, including issuing 1099s to providers?

6. Do you agree to the School District retaining property rights, for the School District's own use, to all materials, reports, produced by the administrator specifically for the School District?

7. What information do you need from the School District initially and on an ongoing basis as it pertains to file uploads?

8. Will you maintain books, records, documents, and evidence on costs and expenses for services provided?

WELLNESS/DISEASE MANAGEMENT

Attach necessary explanations and/or deviations.

1. Are you able to offer a program similar to the Better You Worksite Wellness program?

2. Does your proposal include any additional wellness benefits such as health screenings (i.e. skin cancer screening, vision screening, etc.), flu shot program and/or mini health fairs?

3. Does you proposal include an annual wellness incentive fund or similar program fund for the School District?

4. What incentives do you provide for complying with wellness initiatives? E.g., prevention screenings, reduction in premium for compliance, etc.

5. What type of return on investment should be expected from the wellness program you are proposing? How are you able to measure and demonstrate such a return?

6. What other services or programs do you offer that set you apart from your competitors? What do you do that is especially innovative?

7. Do you have experience either administering or participating in a health fair?

8. Does your proposal include any online and/or telephonic coaching services?

9. What extent of health coaching do you expect to provide, for what conditions?

10. Will an employee being health coached for a condition be able to talk to the same health coach each time, or will the employee have to take whatever health coach is available at the time?

11. Do you have any programs specifically designed for diabetes? Explain.

12. Do you have any programs specifically designed for allergies? Explain.

13. Do you have any programs specifically designed for high blood pressure? Explain.

14. Do you have any programs specifically designed for high cholesterol? Explain.

15. Do you have any programs specifically designed for weight loss? Explain.

16. Do you have ready-made programs for implementation, such as smoking cessation and nutrition?

17. What is your approach to the following items regarding disease management programs?

    h. Identifying persons at risk (i.e. Health Risk Assessment).
    i. Intervention and your basis for such.
    j. Educating targeted persons to take an active role in disease prevention/ management.
    k. Conduct of on-going (e.g. monthly) activities and programs to encourage continuous commitment by participants
    l. Coordination of providers and cost-efficiently maximizing their involvement.
    m. Management of chronic diseases.
    n. Measuring the results.

18. Which of the following diseases/conditions/procedures are targeted in your disease management program? Check in the column left of each item, if you are involved.

	Acid Related Disorders		High Cholesterol
	Allergies		Hypertension
	ALS (Amyotrophic Lateral Sclerosis)		Inflammatory Bowel Disease
	Arthritis (Rheumatoid)		Irritable Bowel Syndrome
	Asthma		Joint Pain
	Atrial Fibrillation		Kidney Disease (Chronic)
	Back pain		Lung disease (chronic obstructive)
	Cancer, incl breast, colon, prostate, skin		Lupus Erythematosis (Systemic)
	COPD		Maternity
	Congestive heart failure		Migraine
	Coronary artery disease		Multiple Sclerosis
	Crohn’s Disease		Musculoskeletal (excluding low back)
	Cystic Fibrosis		Myasthenia Gravis
	Depression		Osteoarthritis
	Dermatomyositis		Osteoporosis
	Diabetes		Parkinson’s Disease
	Fibromyalgia		Prostatic Hyperlasia (Benign)
	Gastroesophageal reflux		Renal Disease (End Stage)
	Gaucher Disease		Scleroderma
	Hemophilia		Seizure Disorders
	Hepatitus		Sickle Cell Anemia
	HIV		Transplants
	High Blood Pressure		Uterine Conditions (Benign)

19. Which of these diseases/conditions/procedures are prime targets in your involvement?

20. How do you plan to coordinate medical claims, pharmacy and other sources of data to maximize the effectiveness of the wellness program?

21. Do your disease management programs take into consideration care for males versus females, age differences, etc.?

22. What specific services or programs do you offer towards age-recommended testing (i.e. PSA tests, mammograms, etc.)?

23. What kind of credentials are held by the persons who are going to provide the basic wellness/disease management services you are proposing; e.g., will they include nurses, doctors, etc.?

24. What supplemental support for non-covered services can you make available? Do you have wellness items/services that are automatically included as part of your program, such as fitness club memberships, Nutri-System, discount bicycle helmets, Jenny Craig, Weight Watchers, etc.

25. What local partnerships can you help develop, e.g. discounts at local gyms, YMCA, YWCA, etc.

MEDICAL & PRESCRIPTION ADMINISTRATOR STABILITY

Attach necessary explanations and/or deviations.

1. Provide your current financial rating from A.M. Best and your current Financial Outlook.

Rating Firm	Rating
A.M. Best	______
Financial Outlook	______

2. Are you rated by NCQA? What is your rating?

3. Is the insurer authorized to do business in Florida?

4. Does your proposed program comply with all applicable Federal and Florida Statutes regarding group insurance, PPOs and HDHPs, and will you assure future compliance?

5. Briefly describe your organization and its history, number of years of providing services, legal structure, and ownership.

6. What year did the insurer begin business in Florida?

7. How many employees does your company have?

8. How many employees does your company have in Florida?

9. What comments can you offer in assurance of your financial stability and your long term commitment to the Florida market, especially with regard to School District and surrounding Counties?

HRA/HSA ADMINISTRATOR STABILITY

1. Is the administrator authorized to do business in Florida?

2. Does your proposed program comply with all applicable Federal and Florida Statutes regarding HSAs, and will you assure future compliance?

3. Briefly describe your organization and its history, number of years of providing services, legal structure, and ownership.

4. What year did the administrator begin business in Florida?

5. How many employees does your company have?

6. How many employees does your company have in Florida?

7. What comments can you offer in assurance of your financial stability and your long term commitment to the Florida market, especially with regard to School District and surrounding Counties?

MEDICAL & PRESCRIPTION ADMINISTRATOR CLIENT REFERENCES

1. Indicate the number of currently contracted employers in the State of Florida.

2. Indicate the number of currently contracted public-sector employers in the State of Florida.

3. List a minimum of four (4) current clients with similar size and/or industry as the School District with the following information:

    - Client Name
    - Contact Name and Title
    - Address
    - Phone and Fax
    - Email Address
    - Length of Client Relationship
    - State if a current or past client
    - Insurance Services Provided
    - Number of Employees

Please note: references must be specific to the proposed coverage(s) and/or service(s).

HRA/HSA CLIENT REFERENCES

1. Indicate the number of currently contracted employers in the State of Florida.

2. Indicate the number of currently contracted public-sector employers in the State of Florida.

3. List a minimum of four (4) current clients with similar size and/or industry as the School District with the following information:

    - Client Name
    - Contact Name and Title
    - Address
    - Phone and Fax
    - Email Address
    - Length of Client Relationship
    - State if a current or past client
    - Insurance Services Provided
    - Number of Employees

Please note: references must be specific to the proposed coverage(s) and/or service(s).

DEVIATIONS FROM MODEL PROGRAM

Indicate whether your proposal will or will not comply with the RFP with respect to the coverage, service or provision listed below. All endorsements set forth in the RFP are to be included VERBATIM in the contract unless indicated to the contrary on the Proposal Form. The absence of any notation will be presumed to indicate full compliance.

Section	RFP Provisions	Will	Will Not
II	Minimum Qualifications of Proposer		
II	Insurance Requirements		
II	Late Proposals, Late Modifications and Late Withdrawals		
II	Costs Incurred by Proposers		
II	Oral Presentation		
II	Exception to the RFP		
II	Proprietary Information		
II	Waiver/Rejection of Proposals		
II	Negotiations of Proposals		
II	Rules, Regulations and Licensing Requirement		
II	Records/Audit		
II	Investigation of Alleged Wrongdoings, Litigation/Settlement/Fines/Penalties		
II	Conduct of Proposers		
II	Conflict of Interest		
II	Legal Requirements		
II	Public Entity Crimes Statement		
II	Anti-Discrimination Clause		
II	Discriminatory Vendor's List		
II	State Licensing Requirement		
II	Drug Free Workplace		
II	Use of Proposal Forms		
II	Irrevocability of Proposal		
II	Contract Awards		
II	Agent/Broker Services		
II	Agent of Record		
II	Deviations from Model Program		
III	Prohibition of Warranty Endorsement		
III	Sole Agent Endorsement		
III	Hold Harmless/Indemnification Provision		
III	Termination and Non-Renewal Endorsement		
III	Rerating Endorsement		
V	Contract Period		
V	Rate Guarantee Period		
V	Remuneration		
V	Access to Claim Files		
V	Ownership of Claim Data		
V	Audit Requirement		
V	Eligibility & Enrollment		
V	Continuity of Coverage (No Loss/No Gain)		
V	Scope of Coverage		

V	Pooling Point		
V	Scope of Services		
V	Managed Care Services		
V	Administrative Services		
V	Healthcare Reform Services		
V	Prescription Benefit Services		
V	Employee Assistance Program Services		
V	Health Savings Account Administration		
V	Medical & Prescription Reporting & Data Services		
V	Wellness Program and Disease Management Services		
V	Performance Guarantees		

ADDITIONAL COMMENTS/DEVIATIONS FROM MODEL PROGRAM

If your proposal does not fully comply with any provision, condition or requirement in this RFP, explain fully (*attach and identify additional pages as necessary*) the alternative provision, condition or requirement proposed.

ACKNOWLEDGMENT OF RECEIPT OF ADDENDA

The Proposer hereby acknowledges receipt of the following addenda:

1. __________ 2. _______ 3. _______ 4. ________

CHECKLIST OF MATERIAL TO BE INCLUDED

The following material should be included as part of each of the completed responses to this RFP including: one (1) paper original and one (1) paper copy (total of two (2) paper proposals) and three (3) Thumb Drives (with all documents in their original format, Word, Excel, etc.)

1. Completed Proposal Forms, and specimen contracts or policies as described in this RFP.

2. Acknowledgment of any addenda.

3. Specimen copy or samples of the following:

    a. Benefit booklets
    b. Benefits Match-Up a,b,c Exhibit 3– In Word format
    c. Network provider (and pharmacy directories)
    d. Most Utilized Providers Exhibit 4– In Excel format
    e. Explanation of Benefits Statement
    f. ID cards and claim forms
    g. Claims and exposure report samples
    h. HSA reports

4. Descriptive literature on Utilization Management Services Program, Medical Case Management, Prescription Drug Program, Employee Assistance Program and HSA System/Capabilities.

5. Completion of financial ratings as outlined under "Medical and Prescription Administrator Stability" and "HSA Administrator Stability."

6. Information on experience and references as requested on Proposal Forms.

PROPOSER'S WARRANTY

The undersigned person, by the undersigned's signature affixed hereon, warrants that:

1. The undersigned is an officer, partner or a sole proprietor of the firm (administrator) and the enclosed proposal is submitted on behalf of the firm;

2. The undersigned has carefully reviewed all the materials and data provided on the insurer's proposal on behalf of the insurer, and, after specific inquiry, believes all the material and data to be true and correct;

3. The proposal offered by the insurer is in full compliance with the Minimum Qualifications of Proposer set forth in Section II of this RFP;

4. The insurer authorizes the School District, its staff or consultants to contact any of the references provided in the proposal and specifically authorizes such references to release either orally or in writing any appropriate data with respect to the insurer offering this proposal;

5. The undersigned has been specifically authorized to issue a contract in full compliance with all requirements and conditions, as set forth in this RFP, other than those deviations noted above;

6. If this proposal is accepted, the contract will be issued as proposed.

____

Name of Firm/Insurer

____

Signature of Authorized Representative

____

Printed Name of Authorized Representative

____

Title of Authorized Representative

____

SCHOOL DISTRICT OF HENDRY COUNTY

Section XI

Proposal Forms for Stop-Loss Insurance

SECTION XI

THE SCHOOL DISTRICT OF HENDRY COUNTY

STOP-LOSS INSURANCE

PROPOSAL FORMS

A. PROPOSER'S IDENTIFICATION

Name of Insurer: ______________________________

FEIN/SS#: ______________________________

Address: ______________________________

____

____

Insurer Proposal Contact: ______________________________

Telephone Numbers Daytime/After Hours: ______________________________

E-mail: ______________________________

B. IF APPLICABLE – INSURANCE AGENCY(IES)/AGENT(S)

NOTE: If one or more agencies/agents are acceptable to the proposing insurer, please list those firms and representatives which you approve, if the School District should decide on a proposal other than directly through the proposing insurer's employee agent:

	Agency	**Agent**
4.	______________________	______________________
5.	______________________	______________________
6.	______________________	______________________

NOTE: If an agent(s) is/are listed, the Agents proposal forms at the end of this document, Section XII - Agent/Broker Services must be completed by each of such agent(s).

STOP-LOSS COST INFORMATION

For the purpose of responding to these questions, the distribution of employees and dependents is to be proposed exactly as indicated. Complete the following chart with the rates/information for providing the stop-loss coverage.

Please complete the charts below based on the proposed coverage:

Unlimited Specific Coverage
Same as or as reasonably to:
Current Aetna MC Plan 1 Medical Plan, including Rx

NETWORK:	Specific Stop-Loss		Aggregate Stop-Loss	
Limit of Liability Per Covered Unit	Unlimited		$1,000,000	
Retention (Deductible)	$200,000		125% of expected claims	
Basis	Paid		Paid	
Reimbursement Factor	100%		100%	
Monthly Premium Per Covered Unit	EE Only 767	EE + Family 56	EE Only 767	EE + Family 56
Composite Rate	$		$	
Single/Family Rate	$	$	$	$
Annual Premium	$		$	
Expected Annual Claims	N/A		$	
Aggregate Attachment Point	N/A		$	

Unlimited Specific Coverage
Same as or as reasonably to:
Current Aetna MC Plan 2 Medical Plan, including Rx

NETWORK:	Specific Stop-Loss		Aggregate Stop-Loss	
Limit of Liability Per Covered Unit	Unlimited		$1,000,000	
Retention (Deductible)	$200,000		125% of expected claims	
Basis	Paid		Paid	
Reimbursement Factor	100%		100%	
Monthly Premium Per Covered Unit	EE Only 19	EE + Family 90	EE Only 19	EE + Family 90
Composite Rate	$		$	
Single/Family Rate	$	$	$	$
Annual Premium	$		$	
Expected Annual Claims	N/A		$	
Aggregate Attachment Point	N/A		$	

Unlimited Specific Coverage
Same as or as reasonably to:
Current <u>Aetna MC Plan 3 HRA/HSA</u> Medical Plan, including Rx

NETWORK:	Specific Stop-Loss		Aggregate Stop-Loss	
Limit of Liability Per Covered Unit	Unlimited		$1,000,000	
Retention (Deductible)	$200,000		125% of expected claims	
Basis	Paid		Paid	
Reimbursement Factor	100%		100%	
Monthly Premium Per Covered Unit	EE Only 24	EE + Family 26	EE Only 24	EE + Family 26
Composite Rate	$		$	
Single/Family Rate	$	$	$	$
Annual Premium	$		$	
Expected Annual Claims	N/A		$	
Aggregate Attachment Point	N/A		$	

<u>STOP-LOSS COST QUESTIONS</u>

1. Does specific coverage apply to all conditions for each person or separately to each condition?

2. When the specific cap is reached, when will the School District receive reimbursement?
   a) Monthly
   b) End of Calendar Year
   c) End of Contract/Plan Year
   d) Other (explain)

3. Recite the policy wording for the definition of experimental procedure and indicate specifically what is not covered.

4. Does the aggregate contract include a monthly advance feature? If so, please describe.

5. Is an intermediary or Managing General Underwriter (MGU) utilized in connection with this proposal? If so, please provide details.

6. Are rates subject to change at final underwriting? If Yes, specify conditions.

7. Please provide a complete copy of the assumptions used in this proposal.

8. Is agent/broker remuneration included in your fees or rates?

9. Please state the amount of remuneration.

10. Also, provide an estimate of the annual remuneration payable.

STOP-LOSS COVERAGE QUESTIONS

1. Is the coverage separable from your administration proposal?

2. Which medical provider network(s) does your stop-loss proposal assume?

3. Which pharmacy provider network(s) does your stop-loss proposal assume?

4. Is coverage based on the current benefits described in the Exhibits? If not, please describe.

5. Is the coverage on a Paid basis? If not, explain the basis on which the coverage is proposed. If a broader coverage basis is available, please describe.

6. Describe the aggregate coverage proposed.

7. Please confirm that transplants and prescription drugs are covered.

8. Are the costs of clinical trials included in the coverage?

STOP-LOSS SERVICE INFORMATION

1. Indicate the location of the office that will service this account, as well as the name of the account representative.

2. Who will be responsible for filing the medical and prescription claims?

3. Describe the process for filing claims and the accounting and reconciliation of claims.

4. Where is the servicing facility located?

5. Are you offering any specialized services as part of your proposal that you consider unique or different to your competitors?

6. Can you provide a quarterly report of claims nearing eligibility for specific coverage?

STOP-LOSS INSURER STABILITY

1. Is the stop-loss insurer authorized to do business in Florida?

2. Briefly describe your organization and its history, number of years of providing services, legal structure, and ownership.

5. What is your current A.M. Best financial rating and financial outlook?

STOP-LOSS CLIENT REFERENCES

1. Indicate the number of currently contracted employers in the State of Florida.

2. Indicate the number of currently contracted public-sector employers in the State of Florida.

3. List a minimum of four (4) current clients with similar size and/or industry as the School District with the following information:

- Client Name
- Contact Name and Title
- Address
- Phone and Fax
- Email Address
- Length of Client Relationship
- State if a current or past client
- Number of Employees

Please note: references must be specific to the proposed coverage(s) and/or service(s).

DEVIATIONS FROM MODEL PROGRAM

Indicate whether your proposal will or will not comply with the RFP with respect to the coverage, service or provision listed below. All endorsements set forth in the RFP are to be included VERBATIM in the contract unless indicated to the contrary on the Proposal Form. The absence of any notation will be presumed to indicate full compliance.

Section	RFP Provisions	Will	Will Not
II	Minimum Qualifications of Proposer		
II	Insurance Requirements		
II	Late Proposals, Late Modifications and Late Withdrawals		
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II	Negotiations of Proposals		
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II	Records/Audit		
II	Investigation of Alleged Wrongdoings, Litigation/Settlement/Fines/Penalties		
II	Conduct of Proposers		
II	Conflict of Interest		
II	Legal Requirements		
II	Public Entity Crimes Statement		
II	Anti-Discrimination Clause		
II	Discriminatory Vendor's List		

II	State Licensing Requirement		
II	Drug Free Workplace		
II	Use of Proposal Forms		
II	Irrevocability of Proposal		
II	Contract Awards		
II	Agent/Broker Services		
II	Agent of Record		
II	Deviations from Model Program		
III	Prohibition of Warranty Endorsement		
III	Sole Agent Endorsement		
III	Hold Harmless/Indemnification Provision		
III	Termination and Non-Renewal Endorsement		
III	Rerating Endorsement		
VI	Contract Period		
VI	Rate Guarantee Period		
VI	Remuneration		
VI	Ownership of Claim Data		
VI	Eligibility & Enrollment		
VI	Continuity of Coverage (No Loss/No Gain)		
VI	Scope of Coverage		
VI	Account Management		

ADDITIONAL COMMENTS/DEVIATIONS FROM MODEL PROGRAM

If your proposal does not fully comply with any provision, condition or requirement in this RFP, explain fully (*attach and identify additional pages as necessary*) the alternative provision, condition or requirement proposed.

CHECKLIST OF MATERIAL TO BE INCLUDED

The following material should be included as part of each of the completed responses to this RFP including: one (1) paper original and one (1) paper copy (total of two (2) paper proposals) and three (3) Thumb Drives (with all documents in their original format, Word, Excel, etc.)

1. Completed Proposal Forms, and specimen contracts or policies as described in this RFP.
2. Acknowledgment of any addenda.
3. Specimen copy or samples of the following:
    a. Stop Loss Policy example
4. Completion of financial ratings as outlined under “Stop Loss Stability.”
5. Information on experience and references as requested on Proposal Forms.

PROPOSER'S WARRANTY

The undersigned person, by the undersigned's signature affixed hereon, warrants that:

1. The undersigned is an officer, partner or a sole proprietor of the firm (insurer) and the enclosed proposal is submitted on behalf of the firm;

2. The undersigned has carefully reviewed all the materials and data provided on the insurer's proposal on behalf of the insurer, and, after specific inquiry, believes all the material and data to be true and correct;

3. The proposal offered by the insurer is in full compliance with the Minimum Qualifications of Proposer set forth in this RFP;

4. The insurer authorizes the School District, its staff or consultants to contact any of the references provided in the proposal and specifically authorizes such references to release either orally or in writing any appropriate data with respect to the insurer offering this proposal;

5. The undersigned has been specifically authorized to issue a contract in full compliance with all requirements and conditions, as set forth in this RFP, other than those deviations noted above;

6. If this proposal is accepted, the contract will be issued as proposed.

____

Name of Firm/Insurer

____

Signature of Authorized Representative

____

Printed Name of Authorized Representative

____

Title of Authorized Representative

____

Date Signed by Authorized Representative

SCHOOL DISTRICT OF HENDRY COUNTY

Section XII

Proposal Forms for Agent/Broker Services

SECTION XII

THE SCHOOL DISTRICT OF HENDRY COUNTY

AGENT/BROKER SERVICES

PROPOSAL FORMS

For agents who are not employees of the insurance company proposed.

AGENT IDENTIFICATION

Agent
Account Representative: ______________________________

Agent's Firm: ______________________________

FEIN/SS#: ______________________________

Address: ______________________________

____

____

Telephone Numbers
Daytime: ______________________________

After Hours: ______________________________

E-mail: ______________________________

COST INFORMATION

Indicate the amount of remuneration you anticipate receiving for:

Coverage/Service	Method of Remuneration	First Year	Second Year
Fully Insured Medical Insurance		$	$
Medical/Rx Claims Administration Services		$	$
Stop-Loss Insurance		$	$
Employee Assistance Program		$	$

1. Is the above amount subject to a minimum and/or maximum? Explain.

2. State any remuneration guarantees for the second and subsequent years, if the School District should accept your proposal for the first year.

3. Do you agree to full disclosure of all remuneration, whether in the form of commission or fees or other?

4. Are you willing to negotiate services and remuneration?

5. The School District currently utilizes the employee agent of its current insurer. Do you understand that if the School District chooses you and your firm to supplement the services automatically provided by the successful insurer that the School District reserves the right to determine if it will continue your services for a second and/or subsequent year(s) subject to the School District's option to return to utilization of the insurer's employee/agent?

Insurers may also quote on a "direct" basis through an employee agent.

The School District assumes that some insurers who propose medical benefits will permit more than one independent insurance agent to represent them, subject to the School District's choice of which one, if the School District should want an independent insurance agent. However, the School District will limit its selection to only those agents designated by such insurers in their proposals.

Medical insurers are encouraged to provide proposals for their benefit plans "net" of independent agent remuneration. The School District will review agent remuneration separate from medical proposals.

Proposing agents are expected to explain the full extent of services to be provided to the School District for the remuneration paid.

SERVICE INFORMATION

Background information should be furnished on proposing agents and/or other key agency personnel that will service the School District.

1. Briefly describe your organization and its history, number of years of providing services, legal structure, ownership and personnel. Such information should include size of agency, experience in providing insurance for public entities, personnel and qualifications (particularly of the agent who will serve the School District).

2. Where is your office located?

   a. If not local, can the School District contact your office by a toll-free number?

   b. Indicate the name of the individual that will service this account.

   c. Provide details on the service(s) your firm would provide to the School District.

3. If selected by the School District, do you agree to provide the services to the School District that are listed in the Scope of Services in the Model Program for Agent Services in the RFP? If not, please explain which services you are unable or unwilling to provide.

4. If you are the proposing agent on the medical claims administration services, do you agree to provide the following services to the School District, including, but not limited to:

   a. Provide assistance with elevated claims issues?
   b. Provide enrollment assistance, including attending enrollment meetings?
   c. Provide renewal assistance?
   d. Provide assistance with any disputes arising between the Plan Sponsor and the selected claims administrator?
   e. Attend regular meetings with staff/committee?
   Explain any deviations.

5. If you are the proposing agent on the stop-loss coverage, do you agree to provide the following services to the School District, including, but not limited to:

   a. Provide assistance with stop-loss claim filing?
   b. Provide renewal assistance to include stop-loss negotiations?
   c. Provide assistance with any disputes arising between the Plan Sponsor and the selected stop-loss carrier?
   Explain any deviations.

6. In addition, if you are the proposing agent on the stop-loss coverage, explain in detail the process for filing claims, who files claims and the accounting and reconciliation of claims.

7. Identify below any additional information about your proposal that the School District should consider (attach and identify additional pages as necessary).

WELLNESS/DISEASE MANAGEMENT

The School District is interested in all Wellness and Disease Management services offered by proposers. Please provide details in your proposal of all current program offerings you can provide as an agent/agency including, if applicable, any additional cost.

The School District is interested in proactive wellness and disease management initiatives, including participation incentives, including but not limited to health screenings, flu shot programs, health risk assessments and health fairs. Proposals should detail the support staff and other assistance that will be provided.

1. Have you indicated (provide an attachment if appropriate) the extent to which you proactively and/or automatically involve yourself with wellness and disease management and similar services?

2. Please describe the wellness initiatives/services you will provide for the School District.

CLIENT REFERENCES

1. Indicate the number of currently contracted employers in the State of Florida.

2. Indicate the number of currently contracted public-sector employers in the State of Florida.

3. List a minimum of four (4) current clients with similar size and/or industry as the School District with the following information:

    - Client Name
    - Contact Name and Title
    - Address
    - Phone and Fax
    - Email Address
    - Length of Client Relationship
    - State if a current or past client
    - Insurance Services Provided
    - Number of Employees

Please note: references must be specific to the proposed coverage(s) and/or service(s).

DEVIATIONS FROM MODEL PROGRAM

Indicate whether your proposal will or will not comply with the RFP with respect to the coverage, service or provision listed below. All endorsements set forth in the RFP are to be included VERBATIM in the contract unless indicated to the contrary on the Proposal Form. The absence of any notation will be presumed to indicate full compliance.

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II	Conflict of Interest		
II	Legal Requirements		
II	Public Entity Crimes Statement		
II	Anti-Discrimination Clause		
II	Discriminatory Vendor's List		
II	State Licensing Requirement		
II	Drug Free Workplace		
II	Use of Proposal Forms		
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II	Contract Awards		
II	Agent/Broker Services		
II	Agent of Record		
II	Deviations from Model Program		
III	Prohibition of Warranty Endorsement		
III	Sole Agent Endorsement		
III	Hold Harmless/Indemnification Provision		
III	Termination and Non-Renewal Endorsement		
III	Rerating Endorsement		
VII	Applicability of this Section		
VII	Contract Period		
VII	Scope of Services		
VII	Remuneration		
VII	Wellness Program and Disease Management Services		

ADDITIONAL COMMENTS/DEVIATIONS FROM MODEL PROGRAM

If your proposal does not fully comply with any provision, condition or requirement in this RFP, explain fully (*attach and identify additional pages as necessary*) the alternative provision, condition or requirement proposed.

ACKNOWLEDGMENT OF RECEIPT OF ADDENDA

The Proposer hereby acknowledges receipt of the following addenda:

1. ________ 2. _______ 3. _______ 4. ________

CHECKLIST OF MATERIAL TO BE INCLUDED

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1. Completed Proposal Forms, and specimen contracts or policies as described in this RFP.
2. Acknowledgment of any addenda.
3. Information on experience and references as requested on Proposal Forms.

PROPOSER'S WARRANTY

The undersigned person, by the undersigned's signature affixed hereon, warrants that:

1. The undersigned is an officer, partner or a sole proprietor of the firm (proposer) and the enclosed proposal is submitted on behalf of the firm;

2. The undersigned has carefully reviewed all the materials and data provided in the proposer's proposal on behalf of the proposer, and, after specific inquiry, believes all the material and data to be true and correct;

3. The proposal offered by the proposer is in full compliance with the Minimum Qualifications of Proposer set forth in Section II of this RFP;

4. The proposer authorizes the School District, its staff or consultants to contact any of the references provided in the proposal and specifically authorizes such references to release either orally or in writing any appropriate data with respect to the insurer offering this proposal;

5. The undersigned has been specifically authorized to issue a contract in full compliance with all requirements and conditions, as set forth in this RFP, other than those deviations noted above;

6. If this proposal is accepted, the contract will be issued as proposed.

____

Name of Firm/Insurer

____

Signature of Authorized Representative

____

Printed Name of Authorized Representative

____

Title of Authorized Representative

____

Date Signed by Authorized Representative